

AMENDED IN ASSEMBLY JUNE 24, 2024

SENATE BILL

No. 159

Introduced by Committee on Budget and Fiscal Review

January 18, 2023

~~An act relating to the Budget Act of 2023.~~ *An act to amend Sections 7903, 16310, 30026.5, and 100520.5 of, and to add and repeal Section 12536 of, the Government Code, to amend Sections 1212, 1214, 1214.1, 1266, 1266.5, 1341.45, 1389.25, 1728.1, 1749, 51312, 120956, 120960, 123322, and 129385 of, to add Section 120972.2 to, to add Chapter 5 (commencing with Section 131360) to Part 1 of Division 112 of, and to add and repeal Section 104751 of, the Health and Safety Code, to amend Section 10113.9 of, and to amend, repeal, and add Section 12693.74 of, the Insurance Code, to amend Sections 1182.14 and 1182.15 of, and to add Section 1182.16 to, the Labor Code, to amend Sections 1001.36, 1370, and 1372 of the Penal Code, to repeal Section 30130.59 of the Revenue and Taxation Code, to amend Section 14902 of the Vehicle Code, and to amend Sections 4361, 5014, 5349, 5813.5, 5840, 5840.6, 5845, 5845.1, 5847, 5849.35, 5886, 5890, 5891, 5892, 5892.5, 5893, 5895, 5899, 5961.4, 14105.192, 14105.201, 14105.467, 14124.12, 14131.05, 14154, 14184.10, 14197.4, 14197.7, 14199.72, 14705, 15840, 15853, and 15893 of, to amend, repeal, and add Sections 14105.200 and 15832 of, to add Sections 7296, 14105.468, 14197.6, and 15877 to, and to add and repeal Article 3.1 (commencing with Section 14124.160) of Chapter 7 of Part 3 of Division 9 of, and to repeal Sections 14105.202 and 14165.58 of, the Welfare and Institutions Code, relating to health, and making an appropriation therefor, to take effect immediately, bill related to the budget.*

LEGISLATIVE COUNSEL'S DIGEST

SB 159, as amended, Committee on Budget and Fiscal Review.
~~Budget Act of 2023-Health.~~

(1) Existing law establishes the Health Care Affordability Reserve Fund and authorizes the Controller to use funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund. Existing law authorizes a loan from the Health Care Affordability Reserve Fund to the General Fund and requires the loan to be repaid in the 2025–26 fiscal year.

This bill would delay repayment of the loan and require 3 payments of \$200,000,000 over 3 fiscal years beginning with the 2026–27 fiscal year.

(2) Existing law provides for the licensure and regulation of health facilities, clinics, home health agencies, and hospice agencies, as defined, by the State Department of Public Health. A violation of these provisions by a licensee is a crime. Existing law prescribes the method for determining licensing and certification fees and requires the department to annually post on its internet website a list of the estimated department fees for the facilities that it licenses.

This bill would require the posted fees to include, but not be limited to, annual licensing, report of change application, and written notification fees, and would make conforming changes to reflect the inclusion of fees other than annual fees. The bill would establish late payment penalties for delinquent fees, as specified. The bill would revise existing licensing provisions for those facilities, to replace references to the department and its Licensing and Certification Division with references to the Licensing and Certification Program (program). The bill would delete various obsolete provisions, including a related fee schedule, and would replace references to renewal fees with references to an annual license fee.

(3) Existing law requires any person, firm, association, partnership, or corporation desiring a license for clinics, home health agencies, and hospice agencies to submit an application containing specified information to the department.

This bill would require the application information to be provided to the program upon initial application for licensure. The bill would require any change in the information that requires the licensee to submit a report of change or written notification to the program to be

provided within 10 business days of the change along with any applicable fee, unless otherwise specified.

Because a violation of the bill's requirements by those facilities would be a crime, the bill would impose a state-mandated local program.

(4) Existing law establishes the Office of Oral Health within the State Department of Public Health. Existing law requires the department to maintain a dental program in order to, among other things, develop comprehensive dental health plans to maximize utilization of all resources. Existing law, the Song-Brown Health Care Workforce Training Act, creates a state medical contract program with specified educational entities and programs to maximize the delivery of primary care to specific areas of California where there is a recognized unmet priority need for those services.

This bill would, until June 30, 2029, require the Office of Oral Health to support the establishment of community-based clinical education rotations for dental students in their final year or dental residents. The bill would require the office to compile data and prepare a report to be submitted to the Legislature on or before July 1, 2027, on specified desired outcomes.

(5) Existing law, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. That act allocates those revenues for specified purposes, including \$30,000,000 to provide funding to the State Department of Public Health state dental program, as specified. Under existing law, if there is a reduction in revenues resulting from a reduction in the consumption of cigarettes and tobacco products due to the additional taxes imposed on cigarettes, the amount of funds allocated to specified programs, including the state dental program, is required to be reduced proportionally. If the allocations to the state dental program are reduced, existing law backfills the reduced amount by continuously appropriating moneys from the General Fund in an amount equivalent to the reduction, so that the total funding for the state dental program remains at \$30,000,000 annually.

This bill would repeal the continuous appropriation to the state dental program that occurs upon a reduction of allocated funds to the program.

(6) Existing law establishes within the State Treasury the Litigation Deposits Fund (LDF), under the control of the Department of Justice and consisting of moneys received as litigation deposits for which the state is a party to the litigation. The state is a party to a settlement related to electronic cigarettes through which it receives funds for nicotine use remediation.

This bill would establish the Electronic Cigarette Settlements Fund within the State Treasury and would require the State Department of Public Health to administer the fund. The bill would require the Controller, upon order of the Department of Finance, to transfer funds received in the LDF payable to the Department of Justice from the *People of the State of California v. JUUL Labs, Inc., et al.* settlement that are allocated to e-cigarette programs to the fund. The bill would require moneys in the fund, upon appropriation by the Legislature, to be used for activities in accordance with the terms of the settlement and specified department notices. The bill would specify that these provisions would remain operative only until July 1, 2035.

(7) Existing law requires the State Department of Public Health to examine the causes of communicable diseases occurring or likely to occur in the state, and to establish a list of reportable diseases. Existing law requires local health officers to immediately report to the department every discovered or known case or suspected case of those reportable diseases and, in the case of a local epidemic, to report, as requested by the department, all facts concerning the disease, and the measures taken to abate and prevent its spread.

This bill would authorize the department to develop and administer a syndromic surveillance program and, subject to an appropriation, to either designate an existing system or to create a new system that would be required, at a minimum, to provide public health practitioners access to an electronic health system to rapidly collect, evaluate, share, and store syndromic surveillance data, as specified. The bill would require general acute care hospitals with emergency departments to submit specified data electronically to the system in accordance with the schedule, standards, and requirements established by the department, unless the hospital reports its data to the local health department and the local health department reports that data to the department, as specified. The bill would authorize the sharing of collected data with specified entities, including the federal Centers for Disease Control, state and local government entities, and persons with a valid scientific interest, as specified, subject to specified confidentiality requirements.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

(8) Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. Existing law establishes a process by which, if the mental competency of a defendant is in doubt, the defendant's mental competency is evaluated and, if found to be mentally incompetent, the defendant may be committed to the State Department of State Hospitals (DSH) with the goal of returning the defendant to competency, as specified.

This bill would require DSH to coordinate with the sheriff in the county of commitment to transport a defendant who has been committed to a DSH facility once a placement in the facility is available and would require DSH to notify the sheriff and the court if the defendant has not been transported within 90 days from the date of commitment, as specified. The bill would, if the sheriff fails to deliver the defendant within the required period of time, stay the commitment and remove the defendant from the waiting list until notice is provided that the defendant is available for transportation.

(9) Under existing law, if a defendant is committed to a DSH facility, the court must provide specified documents to DSH, including the defendant's medical records, before the defendant is admitted to the facility.

This bill would also, if DSH determines that additional medical or mental health records are required for continuity of care, require any public or private entity holding such records to release the records to DSH upon request, as specified.

(10) Existing law requires DSH, upon a determination that the defendant has regained mental competence, to immediately certify that fact to the court by filing a certificate of restoration with the court. Existing law requires the sheriff to deliver the defendant to the court no later than 10 days following the filing of a certificate of restoration. Existing law provides that the state shall only pay for 10 hospital days following filing of the certificate

This bill would clarify that the state will only pay for 10 calendar days in which the defendant remains confined in a DSH facility following the filing of the certificate.

(11) Under existing law, if a defendant is issued a certificate of restoration or becomes mentally competent after conservatorship, but is not released either on bail or a promise to appear, the defendant may, as specified, be returned to a facility for continued treatment.

This bill would clarify that the defendant may be returned only on the recommendation of the person that issued the certificate of restoration and that the defendant shall be returned to a DSH facility at the discretion of, and as directed by, DSH. The bill would also require the recommendation to include a recommendation regarding the involuntary administration of medication and requires the court to review the recommendation, and, as appropriate, issue or continue an order for the involuntary administration of medication, as specified.

(12) Existing law authorizes the Department of Motor Vehicles (DMV) to issue an identification card to an eligible applicant, as specified. Existing law provides a procedure for a person being released from the custody of a county jail, federal correctional facility, or state hospital facility to obtain a replacement identification card. Existing law also provides a procedure for a person being released from a state correctional facility to obtain an original or replacement identification card.

This bill would provide a procedure for a patient being released from a state hospital facility to also obtain an original identification card. The bill would remove the requirement that an applicant for a replacement identification card have no outstanding identification card fees and would remove the requirement that an applicant for a replacement identification card have a usable photo on file with the DMV if the applicant has a new photo taken. The bill would require the State Department of State Hospitals to assist the applicant in applying for an identification card, as specified, including assistance with obtaining qualifying documentation.

(13) Existing law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer, and makes a violation of these minimum wage requirements a misdemeanor.

Existing law requires, for any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis

clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for covered health care employees to be \$23 per hour from July 1, 2024, to June 30, 2025, inclusive, \$24 per hour from July 1, 2025, to June 30, 2026, inclusive, and \$25 per hour from July 1, 2026, and until as adjusted, as specified.

Existing law requires, for any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, as those terms are defined, the minimum wage for covered health care employees to be \$18 per hour from July 1, 2024, to June 30, 2033, inclusive, and \$25 per hour from July 1, 2033, and until as adjusted, as specified.

Existing law requires, for specified clinics that meet certain requirements, the minimum wage for covered health care employees to be \$21 per hour from July 1, 2024, to June 30, 2026, inclusive, and \$22 per hour from July 1, 2026, to June 30, 2027, inclusive, and \$25 from July 1, 2027, and until as adjusted, as specified.

Existing law requires, for all other covered health care facility employers, the minimum wage for covered health care employees to be \$21 per hour from July 1, 2024, to June 30, 2026, inclusive, \$23 per hour from July 1, 2026, to June 30, 2028, inclusive, and \$25 per hour from July 1, 2028, and until as adjusted, as specified.

Existing law also separately requires, for a licensed skilled nursing facility, as described, in specified circumstances the minimum wage for certain other covered health care employees, as described, to be \$21 per hour from July 1, 2024, to June 30, 2026, inclusive, \$23 per hour from July 1, 2026, to June 30, 2028, inclusive, and \$25 per hour from July 1, 2028, and until as adjusted, as specified.

This bill would provide for a delay of the implementation dates of the above-described minimum wage increases until either of 2 events occur, as specified.

(14) Existing law defines various terms for purposes of these provisions relating to minimum wage schedules for covered health care employees, including a covered health care employee, covered health care facility, and full-time equivalent employee. Existing law excludes certain characteristics from the definition of a covered health care employee, including any work performed in the public sector where the

primary duties performed are not health care services. Existing law excludes certain entities from the definition of a covered health facility, including a skilled nursing facility owned, controlled, or operated by the state. Existing law defines a full-time equivalent employee as the total paid hours at a covered health care facility, as specified, as per Department of Health Care Access and Information guidance, divided by 2,080.

This bill would, instead, exclude from the definition of a covered health care employee any work performed by a public employee where the public employee is not primarily engaged in services, as described, performed for a covered health care facility. For purposes of the definition of a covered health care facility, the bill would, instead, delete the exclusion of a skilled nursing facility owned, controlled, or operated by the State Department of State Hospitals from that definition, and would additionally exclude from that definition any health care facility, as described, that is owned, controlled, or operated by the state or any state agency, as defined, of the executive branch. The bill would define full-time equivalent employee as the total hours paid at a covered health care facility, as specified, divided by 2,080 and would specify the determination of the number of full-time equivalent employees.

(15) Existing law requires a health care minimum wage to be enforceable by, among other things, the Labor Commissioner.

This bill would require a health care minimum wage to be enforceable by the Labor Commissioner through specified procedures. The bill would require the Department of Industrial Relations to amend, supplement, and republish the Industrial Welfare Commission's wage orders to be consistent with these minimum wage provisions, as specified. The bill would require every employer subject to these provisions to post a copy of the order as amended, supplemented, and republished by the Department of Industrial Relations, as specified, and to provide to each employee on the effective date of the earliest minimum wage increase a written notice, as provided.

For covered health care employment where the compensation of the employee is on a salary basis, existing law requires the employee to earn a monthly salary equivalent to no less than 150 percent of the health care worker minimum wage or 200 percent of the minimum wage, as described, for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime under state law, including where the employer is the state, a political subdivision of the state, the University of California, or a municipality.

This bill would instead qualify an employee as exempt from the payment of minimum wage and overtime, as described above, if the employer is a political subdivision of the state, a health care district, the University of California, or a municipality.

(16) Existing law requires the Department of Health Care Access and Information to publish on their internet website a list of all covered health care facility employers, as specified, and a list of all hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. If a covered health care facility believes that they were inappropriately excluded from the list of hospitals that qualify as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility, existing law authorizes the health facility to file a request with the Department of Health Care Access and Information to be classified as a hospital with a high governmental payor mix, independent hospital with an elevated governmental payor mix, or a rural independent covered health care facility. Existing law requires the requesting hospital to provide, among other things, the payor mix of the requesting hospital, as specified.

This bill would require the lists described above to only include those covered health care facility employers included in the Department of Health Care Access and Information's 2021 Pivot Table, as described. The bill would require the requesting hospital to provide, among other things, the revised Annual Disclosure Report, as provided, that reflects the payor mix of the requesting hospital, as specified.

(17) Existing law requires the Department of Industrial Relations, in collaboration with the State Department of Health Care Services and the Department of Health Care Access and Information, to develop, by March 1, 2024, a waiver program for covered health care facilities, as described, which would authorize a covered health care facility to apply for and receive a temporary pause or alternative phase in the schedule of the health care minimum wage requirements, as specified. In order to obtain a waiver, existing law requires a covered health care facility to demonstrate that compliance with the minimum wage requirements would raise doubts about the covered health care facility's ability to continue as a going concern under generally accepted accounting principles, as specified.

In order to obtain a waiver, this bill would instead require a covered health care facility to demonstrate at the time the waiver application

is submitted that it includes, among other things, the covered health care facility's, and any parent or affiliated company's, most recent audited financial statements, as specified, and a declaration verifying that the contents of the documents contained in the waiver request are true and correct. The bill would require the Department of Industrial Relations to make approved financial information available on its internet website, and would require the Department of Health Care Access and Information to make the audited financial information submitted in conjunction with an approved waiver available on its internet website, as specified.

If a waiver is issued, the bill would require any covered health care facility affected by the waiver to, within 10 days of notice from the Department of Industrial Relations, to, among other things, provide to each covered health care employee, a specified written notice, informing the covered health care employee the covered health care facility had applied for and received a one-year waiver of the increase of the minimum wage and stating the applicable minimum wage. The bill would authorize the Department of Industrial Relations and Department of Health Care Access and Information to enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, for purposes of implementing the minimum wage schedule provisions.

By expanding the requirements relating to health care minimum wages, the violation of which would be a crime, the bill would impose a state-mandated local program.

(18) Existing law authorizes the department to contract with a county to help fund the development or expansion of pretrial diversion, as specified. Existing law requires a county so contracted to quarterly report data and outcomes to the department, regarding those individuals targeted by the contract and in the program.

This bill would instead require the county to report monthly, as specified, and would make other conforming changes.

(19) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Under existing law, mental health services are provided through contracts with county mental health programs and the department is authorized to temporarily withhold funds or impose

monetary sanctions on a county behavioral health department that is not in compliance with the contract.

This bill would require that certain funds collected as a result of sanctions between July 1, 2024, and June 30, 2027, be deposited in the General Fund for use, upon an appropriation by the Legislature, for the nonfederal share of Medi-Cal costs for health care services furnished to specified groups.

(20) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services. The MHSA establishes the Mental Health Services Fund. Existing law, the Behavioral Health Services Act (BHSA), approved by the voters as Proposition 1 at the March 5, 2024, statewide primary election, commencing January 1, 2025, revises and recasts the MHSA by, among other things, creating the Behavioral Health Services Fund. Existing law requires that any moneys remaining in the Mental Health Services Fund on January 1, 2025, be transferred to the Behavioral Health Services Fund.

This bill would make conforming technical changes consistent with the creation of, and the transfer of moneys to, the Behavioral Health Services Fund, operative January 1, 2025. The bill would make technical, nonsubstantive changes.

(21) Existing law, the California Special Supplemental Nutrition Food Program for Women, Infants, and Children (WIC Program), authorizes establishment of a statewide program, administered by the State Department of Public Health, for providing nutritional food supplements to low-income pregnant women, low-income postpartum and lactating women, and low-income infants and children under 5 years of age, who have been determined to be at nutritional risk.

Existing law requires the department, in order to effectively manage and administer the federal and state requirements for the vendors in the WIC Program, to establish requirements for peer groups and a corresponding reimbursement system, criteria used for vendor authorization, and WIC Program-authorized foods. Existing law authorizes the department to implement, interpret, or make specific these provisions by bulletin or similar instruction. Existing law requires the department to notify and consult with affected stakeholders in the process of implementing, interpreting, or making specific these provisions, and requires the notice to provide opportunity for written

comment. Existing law requires any final action to be published on the department's internet website no later than 120 days after the consultation with stakeholders or the last day for comments, whichever is later, and deems the final action withdrawn if the department fails to meet this requirement.

This bill would require the department to additionally establish requirements for online shopping and retail food delivery systems. The bill would also require the department to publish the final action no later than 180 days after the consultation with stakeholders or the last day for comments, whichever is later.

The bill would authorize the department, without taking regulatory action, to implement, interpret, or make specific all of the above-mentioned provisions by means of all-county letters, plan letters, information notices, provider bulletins, or other similar instruction. The bill would authorize the department to modify or repeal specified WIC Program requirements by bulletin or similar instruction, without taking further regulatory action, if certain criteria are met.

(22) Existing law establishes the Children and Youth Behavioral Health Initiative, administered by the California Health and Human Services Agency and its departments, as applicable. Under existing law, the purpose of the initiative is to transform the state's behavioral health system into an innovative ecosystem in which all children and youth 25 years of age or younger, regardless of payer, are screened, supported, and served for emerging and existing behavioral health needs.

Existing law requires the State Department of Health Care Services, or a contracted vendor, to provide competitive grants to qualified entities to build partnerships, capacity, and infrastructure supporting ongoing school-linked behavioral health services, among other purposes, for children and youth 25 years of age or younger. For these purposes, existing law requires the department to develop and maintain a school-linked statewide fee schedule for outpatient mental health or substance use disorder treatment provided to a student who is 25 years of age or younger at a schoolsite. Existing law requires the department to develop and maintain a school-linked statewide provider network of schoolsite behavioral health counselors.

This bill would authorize the department to contract with an entity to administer the school-linked statewide behavioral health provider network. The bill would require the entity that administers that network to create and administer a process for enrolling and credentialing

eligible practitioners and providers and a process for the submission and reimbursement of their claims. The bill would require those practitioners and providers to comply with the enrollment, credentialing, and claims processes. The bill would also require a health care service plan, insurer, or Medi-Cal managed care plan that covers necessary schoolsite services, as specified, to comply with all administrative requirements to cover and reimburse the services set forth by the network administrator.

The bill would establish the Behavioral Health Schoolsite Fee Schedule Administration Fund in the State Treasury for specified purposes. The bill would require the department to establish and charge a fee for participating health care service plans, insurers, or Medi-Cal managed care plans to be used to cover the reasonable cost of administering the school-linked behavioral health provider network, as specified. The bill would authorize the department to periodically update the amount and structure of the fee, as specified. The bill would require revenues generated from the fees, less refunds, to be deposited into the fund. This bill would limit the money in the fund to be used upon appropriation by the Legislature, as specified, and would require interest and dividends earned on moneys in the fund to be retained in the fund for specified purposes.

(23) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would, for dates of service no sooner than July 1, 2024, require the department to establish a directed payment reimbursement methodology, or revise one or more existing directed payment reimbursement methodologies, applicable to children's hospitals, as specified. The bill would require Medi-Cal managed care plans to reimburse children's hospitals in accordance with the requirements of the directed payment arrangement established by the department and any guidance issued by the department to implement these provisions. The bill would, commencing no sooner than July 1, 2024, continuously appropriate \$115,000,000 on an annual basis to the department from the General Fund to support payments implemented pursuant to these provisions. The bill would authorize the department to reduce the amount of reimbursements, as specified, if the Protect Access to Healthcare Act of 2024 is approved by the voters and if children's

hospitals receive increased reimbursement rates or payments under certain provisions. The bill would include related legislative intent with regard to these provisions.

(24) Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, proceeds from the taxes are available, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program, including certain payments to Medi-Cal managed care plan and transfers to the Medi-Cal Provider Payment Reserve Fund. Existing law requires the department, upon appropriation, to use moneys transferred to that fund for purposes of funding targeted increases to Medi-Cal payments or other investments, as specified.

This bill would remove, as one of the designated expenditures from that fund, a \$75,000,000 annual transfer to the University of California for expanding graduate medical education programs.

The bill would instead add, as designated expenditures from that fund, a \$40,000,000 transfer to support workforce investments, increased costs relating to continuous eligibility for children up to 5 years of age as described below, and departmental administrative costs for implementing the Medi-Cal Provider Payment Increases and Investments (PPI) Act described below. Under the bill, increased costs for targeted increases would instead be made pursuant to the PPI Act. The bill would repeal those additions if specified provisions relating to the MCO provider tax are approved by the voters at the November 5, 2024, statewide general election.

If those specified provisions are approved by the voters, the bill would instead remove, as a designated expenditure, increased costs for targeted increases to Medi-Cal payments or other investments based on a plan submitted by the department to the Legislature as part of the 2024–25 Governor’s Budget. The bill would repeal provisions regarding that plan.

Under the bill, community health workers would be an eligible provider type for rate increases specified in related provisions under existing law.

(25) Existing law requires the department, upon appropriation, to establish a supplemental payment pool for nonhospital 340B community clinics, relating to discount drug purchasing.

This bill would require the department to establish and implement a directed payment program under which a qualifying nonhospital 340B community clinic may earn payments from contracted Medi-Cal managed care plans, subject to an appropriation and any necessary federal approvals. The bill would set forth the criteria and methodologies for that program, including links to the Medi-Cal Provider Payment Reserve Fund.

Under the bill, for any calendar year in which this program is implemented, neither the department nor a Medi-Cal managed care plan would be required to make the payments specified in the above-described supplemental payment pool. The bill would make conforming changes by repealing the supplemental payment pool-related provisions if certain conditions are met.

(26) This bill would establish the Medi-Cal Provider Payment Increases and Investments (PPI) Act in order to, among other things, improve access to high-quality care for Medi-Cal members and promote provider participation in the Medi-Cal program. The bill would require the department to seek federal approval for various PPI components, including reimbursement increases for professional services, ground emergency medical transport services, abortion services, family planning services, and certain other applicable services, for updating the reimbursement methodology for optional hearing aid benefits, for eliminating certain rate reductions as described below, and for increases to the amount of directed payments for qualifying nonhospital 340B community clinics as described above.

The bill would set forth various provisions to implement those PPI components, including reimbursement methodologies and procedures involving Medi-Cal managed care plans.

Under the bill, payments implemented under PPI would be supported by MCO provider tax revenue or other state funds appropriated by the Legislature, as specified. Except for the portion related to abortion services, the bill would condition PPI implementation on receipt of any necessary federal approvals and the availability of federal financial participation. If a later enacted statute restricts the availability of moneys, including with regard to the MCO provider tax, the bill would require the department to implement PPI or related provisions to the extent that the department determines PPI remains feasible, as specified. The bill would authorize the Director of Health Care Services to make any necessary modifications, as specified.

(27) Existing law sets forth various Medi-Cal payment reductions by specified percentages, including a 10% reduction, for certain services and providers.

This bill would make an exception to some of those payment reductions for physician and professional services, and for abortion services, subject to implementation of the related PPI provisions described above.

(28) Existing law establishes the Healthy Families Program, the Medi-Cal Access Program, and the County Children's Health Initiative Program. Existing law sets forth provisions, operative on January 1, 2025, or as otherwise specified, for the continuous eligibility of an applicable child under those programs up to 5 years of age.

This bill would shift implementation of that continuous eligibility from 2025 to 2026. The bill would also make some changes to the implementation criteria for that continued eligibility.

(29) Under this bill, if specified provisions relating to the MCO provider tax are approved by the voters at the November 5, 2024, statewide general election, most of the changes made by the bill to the provisions listed in paragraphs (24) through (28) would become inoperative, as specified.

(30) Existing law requires, for the duration of the COVID-19 emergency period, the State Department of Health Care Services to implement any federal Medicaid program waiver or flexibility approved by the federal Centers for Medicare and Medicaid Services related to that emergency. Existing law requires, upon expiration of the COVID-19 emergency period and subject to any necessary federal approvals, the department to continue to reimburse the administration of a COVID-19 vaccine at 100% of the Medicare national equivalent rate in effect at the time of vaccine administration without geographic adjustment.

This bill would instead require the department to align COVID-19 vaccine administration payments to payment reimbursement structures for vaccines administered in accordance with the Medi-Cal State Plan.

(31) Existing law requires the State Department of Health Care Services, subject to federal approval, to establish and implement a program or programs under which a designated public hospital system or a district and municipal public hospital, as defined, may earn performance-based quality incentive payments from the Medi-Cal managed care plan with which they contract, as specified. Existing law requires the department, subject to federal approval, to require each Medi-Cal managed care plan to increase contract services payments

to designated public hospital systems by amounts determined under a directed payment methodology that meets certain federal requirements.

This bill would also apply the requirement for increased directed payments to district and municipal public hospitals commencing with the 2023 calendar year. The bill would make certain changes to the directed payment methodology and would make conforming changes to related provisions.

Under existing law, the nonfederal share of the portion of the capitation rates specifically associated with directed payments and for the quality incentive payments may consist of voluntary intergovernmental transfers (IGTs) of funds provided by the hospitals and their affiliated governmental entities, or other public entities, as specified. Existing law prohibits the department from assessing a specified fee on an IGT or any other similar fee.

This bill would remove that prohibition on a fee assessment and would instead authorize the department to assess a fee not to exceed 5% on IGTs to reimburse the department for the administrative costs of operating the programs under these provisions and for the support of the Medi-Cal program.

The bill would make various other changes to related provisions with regard to, among other things, fiscal or rate years during which payments are made.

(32) Existing law requires the State Department of Health Care Services, subject to federal approval, to design and implement an IGT program, with voluntary participation, relating to Medi-Cal managed care services provided by nondesignated public hospitals, as defined, in order to increase capitation payments for the purpose of increasing their reimbursement. Existing law requires that the increased capitation payments be actuarially equivalent to the increased fee-for-service payments made pursuant to a certain other IGT program to the extent permissible under federal law.

This bill would repeal the above-described provisions relating to capitation payments.

(33) Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to federal approval, to follow the predecessor California Medi-Cal 2020 Demonstration Project. Under CalAIM, a designated public hospital is defined as any one of the hospitals identified in the California Medi-Cal 2020 Demonstration Project, and any successor, that is operated by a county, a city and county, the University of California, or a special hospital

authority, or any additional public hospital to the extent identified as a designated public hospital in the CalAIM Terms and Conditions.

This bill would make various changes to the definition of a designated public hospital, including changes to the name or scope of certain hospitals and the addition of other hospitals.

(34) Existing law requires the State Department of Health Care Services to establish and maintain a plan, known as the County Administrative Cost Control Plan, whereby costs for county administration of the determination of eligibility for Medi-Cal benefits are effectively controlled within the amounts annually appropriated for that administration. Existing law expresses the intent of the Legislature not to appropriate funds for certain cost-of-doing-business adjustments, as described, for specified fiscal years.

This bill would additionally express the intent of the Legislature not to appropriate funds for the cost-of-doing-business adjustment for the 2024–25 to 2027–28, inclusive, fiscal years.

(35) Existing law requires the State Department of Health Care Services, upon appropriation, to establish a clinic workforce stabilization retention payment program under Medi-Cal to provide funds to eligible qualified clinics, as defined, to make retention payments to their eligible employees for the public purposes of providing stability in the California qualified clinic workforce and retaining qualified health care workers. To the extent that any appropriated funds remain after the department has distributed funds to eligible qualified clinics for employee retention payments, existing law requires that those excess funds be used for qualified clinic workforce training, as described below.

Under existing law, upon the order of the Director of Finance, any retention payment funding returned under related provisions or unexpended funds left over from a specified appropriation in the Budget Act of 2022 are transferred and available for expenditure or encumbrance through June 30, 2028, to fund workforce development programs that support primary care in clinics, as specified.

This bill would delete the provisions that require that excess funds be used for qualified clinic workforce training and the provisions that require the transfer of returned or unexpended funds and their availability for workforce development programs.

(36) Existing law establishes the Distressed Hospital Loan Program, administered by the Department of Health Care Access and Information, in order to provide interest-free cashflow loans to not-for-profit

hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law establishes the Distressed Hospital Loan Program Fund, with moneys in the fund being continuously appropriated for the department. Existing law authorizes the Department of Finance to transfer up to \$150,000,000 from the General Fund and up to \$150,000,000 from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement the program.

Existing law authorizes the department to allocate an amount not to exceed 5% of total program funds to administer the program, as specified. Existing law requires any funds transferred to be available for encumbrance or expenditure until June 30, 2026.

This bill would instead require any funds transferred to be available for encumbrance or expenditure until December 31, 2031. By extending the amount of time continuously appropriated funds are available for encumbrance and expenditure, the bill would make an appropriation.

(37) Existing law creates the California Major Risk Medical Insurance Program (MRMIP), which is administered by the State Department of Health Care Services, to provide major risk medical coverage through participating health plans to eligible residents of the state who are unable to secure adequate private health care coverage. If a health care service plan or health insurer rejects a dependent to be added to an individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, existing law requires the plan or insurer to inform the applicant about MRMIP.

This bill would require the department to cease to provide coverage through MRMIP on December 31, 2024. The bill would require the department to direct participating health plans to inform subscribers of the transition of coverage at specified intervals, complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, and conduct other necessary termination activities. Upon request of the California Health Benefit Exchange (HBEX) the bill would require the department to disclose information to HBEX to assist MRMIP subscribers to transition to coverage through HBEX, as specified. Commencing November 1, 2024, and ending when

the transition of coverage is complete, the bill would require the department to provide monthly updates to the Assembly Committees on Health and Budget and the Senate Committees on Health and Budget and Fiscal Review about the transition of subscribers. The bill would require a plan or insurer that rejects an above-described application or makes an above-described offer to inform the applicant about MRMIP only if the rejection or offer is before July 1, 2024.

Existing law establishes the Major Risk Medical Insurance Fund and the Health Care Services Plan Fines and Penalties Fund and continuously appropriates moneys in the funds, except as specified, to the department for purposes of MRMIP. Existing law also establishes the Managed Care Administrative Fines and Penalties Fund, from which certain amounts are to be transferred to the Health Care Services Plan Fines and Penalties Fund and continuously appropriated to the department for purposes of MRMIP.

This bill would instead continuously appropriate moneys in the Health Care Services Plan Fines and Penalties Fund to fund the nonfederal share of health care services for children, adults, seniors, persons with disabilities, and dual-eligible beneficiaries in the Medi-Cal program. By changing the purposes of a continuously appropriated fund, the bill would make an appropriation.

(38) Existing law establishes the Behavioral Health Services Oversight and Accountability Commission to promote transformational change in California's behavioral health system, among other things. Beginning January 1, 2025, existing law requires the commission to have an Executive Director, who is responsible for management over the administrative, fiscal, and program performance of the commission. Existing law requires the commission to award grants to county mental health or behavioral health departments to fund partnerships between educational and county mental health entities. Existing law authorizes the commission to exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis to implement that requirement. Until January 1, 2025, existing law exempts those contracts from contracting requirements applicable only to state contracts.

This bill would extend that exemption from contracting requirements indefinitely. The bill would authorize the commission to delegate to the Executive Director any power, duty, purpose, function, or jurisdiction that the commission may lawfully delegate, and would authorize the Executive Director to redelegate, as specified.

Beginning January 1, 2025, existing law creates the Behavioral Health Services Act Innovation Partnership Fund in the State Treasury to fund a program, administered by the commission, to award grants to private, public, and nonprofit partners to promote development of innovative mental health and substance use disorder programs and practices.

This bill would authorize private donations or grants, federal or state grants, any interest on amounts in the fund, and moneys previously allocated that are returned to the fund, as specified, to be paid into the fund.

(39) Existing law authorizes the State Public Health Officer, to the extent allowable under federal law, and upon the availability of funds, to expend money from the AIDS Drug Assistance Program (ADAP) Rebate Fund for the HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and other specified costs. The AIDS Drug Assistance Program Rebate Fund is a continuously appropriated fund.

This bill would, to the extent that the activities are an allowable use of the funds, authorize the State Department of Public Health to spend up to \$23,000,000 to conduct other programs and grants related to the treatment and prevention of HIV and AIDS, such as increase the financial eligibility standards for ADAP, modify the ADAP formulary, and to create, develop, or contract for needs assessment analysis, as specified, among others. The bill would require the State Department of Public Health to report to the Legislature a plan for modernization and expansion of ADAP, as described. By adding to the purposes of a continuously appropriated fund, the bill would make an appropriation.

(40) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(41) This bill would declare that it is to take effect immediately as a bill providing for appropriations related to the Budget Bill.

This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2023.

Vote: majority. Appropriation: ~~no~~-yes. Fiscal committee: ~~no~~
yes. State-mandated local program: ~~no~~-yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 7903 of the Government Code is amended
2 to read:

3 7903. (a) “State subventions” shall, except as provided in
4 subdivision (b), include only money received by a local agency
5 from the state, the use of which is unrestricted by the statute
6 providing the subvention.

7 (b) (1) Commencing with the 2021–22 fiscal year and each
8 fiscal year thereafter, “state subventions” shall also include any
9 money provided to a local agency pursuant to any of the following:

10 (A) Child support administration relating to local child support
11 agencies (Sections 17306, subdivision (b) of Section 17704, and
12 subdivision (a) of Section 17710 of the Family Code).

13 (B) Black Infant Health Program (Section 123255 of the Health
14 and Safety Code).

15 (C) California Home Visiting Program (Section 123255 of the
16 Health and Safety Code).

17 (D) Sexually transmitted disease prevention and control
18 activities (Section 120511 of the Health and Safety Code).

19 (E) Support for vital public health activities (Article 7
20 (commencing with Section 101320) of Chapter 3 of Part 3 of
21 Division 101 of the Health and Safety Code).

22 (F) County administration for Medi-Cal eligibility (Section
23 14154 of the Welfare and Institutions Code).

24 (G) Optional Targeted Low Income Children’s Program (Section
25 14005.27 of the Welfare and Institutions Code).

26 (H) Case management services under the California Children’s
27 Services program (Section 123850 of the Health and Safety Code).

28 (I) Child Health and Disability Prevention Program (Article 6
29 (commencing with Section 124024) of Chapter 3 of Part 2 of
30 Division 106 of the Health and Safety Code).

31 (J) Specialty Mental Health Services (Chapter 8.9 (commencing
32 with Section 14700) of Part 3 of Division 9 of the Welfare and
33 Institutions Code).

34 (K) Specified precare and postcare services for individuals
35 treated in short-term residential therapeutic programs (Article 5

- 1 (commencing with Section 14680) of Chapter 8.8 of Part 3 of
2 Division 9 of the Welfare and Institutions Code).
- 3 (L) Behavioral Health Quality Improvement Program (Section
4 14184.405 of the Welfare and Institutions Code).
- 5 (M) Mental health plan costs for Continuum of Care Reform
6 (Sections 4096.5 and 11462.01 of the Welfare and Institutions
7 Code).
- 8 (N) Mobile crisis services (Section 14132.57 of the Welfare
9 and Institutions Code).
- 10 (O) Los Angeles County Justice-Involved Population Services
11 and Supports (Provision 18 of Item 4260-101-0001 of the Budget
12 Act of 2022).
- 13 (P) Funds distributed from the ~~Mental~~ Behavioral Health
14 Services Fund pursuant to Section 5892 of the Welfare and
15 Institutions Code.
- 16 (Q) Drug Medi-Cal organized delivery system, excluding
17 Narcotic Treatment Program services (Section 14184.401 of the
18 Welfare and Institutions Code).
- 19 (R) Drug Medi-Cal, excluding Narcotic Treatment Program
20 services (Section 14124.20 of the Welfare and Institutions Code).
- 21 (S) Behavioral Health Bridge Housing Program (Provision 17
22 of Item 4260-101-0001 of the Budget Act of 2022).
- 23 (T) Mental Health Student Services Act partnership grant
24 program (Section 5886 of the Welfare and Institutions Code).
- 25 (U) CalFresh (Section 18906.55 of the Welfare and Institutions
26 Code).
- 27 (V) In-Home Supportive Services (Sections 12306.16 and
28 12302.25 of the Welfare and Institutions Code).
- 29 (W) Community Care Expansion Program (Section 18999.97
30 of the Welfare and Institutions Code).
- 31 (X) Housing and Disability Income Advocacy Program (Chapter
32 25 of the Statutes of 2016 (Assembly Bill No. 1603) and Chapter
33 17 (commencing with Section 18999) of Part 6 of Division 9 of
34 the Welfare and Institutions Code).
- 35 (Y) Project Roomkey (Executive Order No. N-32-20 and Item
36 5180-151-0001 of the Budget Act of 2019, Item 5180-151-0001
37 of the Budget Act of 2021, and Item 5180-493 of the Budget Act
38 of 2022).
- 39 (Z) Bringing Families Home Program (Section 16523.1 of the
40 Welfare and Institutions Code).

- 1 (AA) Home Safe Program (Section 15771 of the Welfare and
2 Institutions Code).
- 3 (AB) CalWORKs Housing Support Program (Section 11330.5
4 of the Welfare and Institutions Code).
- 5 (AC) CalWORKs (Section 15204.3 of the Welfare and
6 Institutions Code).
- 7 (AD) Automation (Section 10823 of the Welfare and Institutions
8 Code and Item 5180-141-0001 of the Budget Act of 2022).
- 9 (AE) Adult Protective Services (Chapter 13 (commencing with
10 Section 15750) of Part 3 of Division 9 of the Welfare and
11 Institutions Code).
- 12 (AF) Adult corrections and rehabilitation operations—institution
13 administration (Chapter 3 (commencing with Section 1228) of
14 Title 8 of Part 2 of the Penal Code, Sections 1557 and 4750 of the
15 Penal Code, and Section 26747 of the Government Code).
- 16 (AG) Corrections planning and grant programs (The Safe
17 Neighborhoods and Schools Act (Proposition 47 approved at the
18 November 4, 2014, general election), The Public Safety and
19 Rehabilitation Act of 2016 (Proposition 57 approved at the
20 November 8, 2016, general election), The Control, Regulate, and
21 Tax Adult Use of Marijuana Act (Proposition 64 approved at the
22 November 8, 2016, general election), Section 7599.1 of the
23 Government Code, Title 10.2 (commencing with Section 14130)
24 of the Penal Code, Chapter 337 of the Statutes of 2020 (Senate
25 Bill No. 823), Items 5227-123-0001, 5227-117-0001,
26 5227-118-0001, 5227-120-0001, 5227-121-0001, 5227-125-0001,
27 of the Budget Act of 2022, Items 5227-115-0001 and
28 5227-116-0001 of the Budget Act of 2021).
- 29 (AH) Office of the Small Business Advocate (Item
30 0509-103-0001 of the Budget Act of 2021).
- 31 (AI) Elections (Chapter 9 of the Statutes of 2022 (Senate Bill
32 No. 119) and Item 0890-101-0001 of the Budget Act of 2021).
- 33 (AJ) County Subvention (Items 8955-101-0001 and
34 8955-101-3085 of the Budget Act of 2021).
- 35 (AK) Department of Cannabis Control grant (Item
36 1115-101-0001 of the Budget Act of 2021 and Item 1115-102-0001
37 of the Budget Act of 2022).
- 38 (AL) Agricultural land burning in San Joaquin Valley (Provision
39 1 of Item 3900-101-0001 of the Budget Act of 2021).

1 (AM) Carl Moyer Air Quality Standards Attainment Program
2 (Provision 2g of Item 3970-101-0001 of the Budget Act of 2021).

3 (AN) Pre-positioning for fire and rescue (Provision 3 of Item
4 0690-101-0001 of the Budget Act of 2021 and the Budget Act of
5 2022).

6 (AO) Prepare California (Item 0690-106-0001 of the Budget
7 Act of 2021).

8 (AP) Law Enforcement Mutual Aid (Provision 6 of Item
9 0690-101-0001 of the Budget Act of 2022).

10 (AQ) Los Angeles Regional Interoperable Communication
11 Systems (Provision 9 of Item 0690-101-0001 of the Budget Act
12 of 2022).

13 (AR) Homeless Housing, Assistance, and Prevention program
14 grants (Chapter 6 (commencing with Sections 50216) of Part 1 of
15 Division 31 of the Health and Safety Code).

16 (AS) Encampment resolution grants (Chapter 7 (commencing
17 with Section 50250) and Chapter 8 (commencing with Section
18 50255) of Part 1 of Division 31 of the Health and Safety Code).

19 (AT) Operating subsidies for Homekey facilities (Sections
20 50675.1.1 to 50675.14, inclusive, of the Health and Safety Code).

21 (AU) Various programs contained in Control Sections 19.56
22 and 19.57 of the Budget Act of 2021, and Control Section 19.56
23 of the Budget Act of 2022.

24 (2) State subventions pursuant to programs listed in paragraph
25 (1) shall be included within the appropriations limit of the local
26 agency, up to the amount representing the difference between the
27 total amount of proceeds of taxes of the local agency, calculated
28 without application of this section, and the full appropriations limit
29 of the local agency, as determined pursuant to Section 7902.

30 (c) (1) No later than February 1 of each year, the Department
31 of Finance shall do both of the following:

32 (A) Calculate for each local agency the individual subvention
33 amounts for each program listed in paragraph (1) of subdivision
34 (b).

35 (B) Provide the information described in subparagraph (A) to
36 the California State Association of Counties and the League of
37 California Cities for distribution to local agencies.

38 (2) Local agencies shall utilize the amounts calculated by the
39 Department of Finance and provided to them pursuant to this

1 subdivision for purposes of Article XIII B of the California
2 Constitution and this division.

3 (d) (1) Any portion of state subventions pursuant to programs
4 listed in paragraph (1) of subdivision (b) that exceeds the amount
5 representing the difference between the total amount of proceeds
6 of taxes of the local agency, calculated without application of this
7 section, and the appropriations limit of the local agency shall be
8 identified and reported to the Director of Finance by November
9 1, 2022, and by that date annually thereafter.

10 (2) The Director of Finance shall calculate the total amounts
11 reported by local agencies pursuant to this subdivision and shall
12 include those amounts within the state appropriations limit
13 determined pursuant to Section 7902.

14 (e) The determinations and calculations required pursuant to
15 this section shall be in addition to any determinations and
16 calculations required pursuant to Section 7902.2.2 of the
17 Government Code.

18 *SEC. 2. Section 12536 is added to the Government Code, to*
19 *read:*

20 *12536. (a) The Electronic Cigarette Settlements Fund is hereby*
21 *created in the State Treasury.*

22 *(b) The State Department of Public Health shall administer the*
23 *Electronic Cigarette Settlements Fund.*

24 *(c) Upon order of the Department of Finance, the Controller*
25 *shall transfer funds received in the Litigation Deposits Fund*
26 *payable to the Department of Justice from the settlement of People*
27 *of the State of California v. JUUL Labs Inc., et al. (Alameda*
28 *County Superior Court, No. RG19043543, April 17, 2023) that*
29 *are allocated for People v. JUUL Labs, Inc. E-Cigarette Programs*
30 *to the Electronic Cigarette Settlements Fund.*

31 *(d) Upon appropriation by the Legislature, moneys from the*
32 *Electronic Cigarette Settlements Fund shall be used for activities*
33 *in accordance with the terms of the People of the State of*
34 *California v. JUUL Labs, Inc., et al. settlement and the Department*
35 *of Justice's Notices re: State of California JUUL Settlement*
36 *Funding dated November 13, 2023.*

37 *(e) This section shall remain operative only until July 1, 2035,*
38 *and as of January 1, 2036, is repealed.*

39 *SEC. 3. Section 16310 of the Government Code is amended to*
40 *read:*

1 16310. (a) When the General Fund in the Treasury is or will
2 be exhausted, the Controller shall notify the Governor and the
3 Pooled Money Investment Board. The Governor, or ~~his or her~~ *their*
4 designee, may order the Controller to direct the transfer of all or
5 any part of the moneys not needed in other funds or accounts to
6 the General Fund from those funds or accounts, as determined by
7 the Pooled Money Investment Board, including the Surplus Money
8 Investment Fund or the Pooled Money Investment Account. All
9 moneys so transferred shall be returned to the funds or accounts
10 from which they were transferred as soon as there are sufficient
11 moneys in the General Fund to return them. No interest shall be
12 charged or paid on any transfer authorized by this section, exclusive
13 of the Pooled Money Investment Account, except as provided in
14 this section. This section does not authorize any transfer that will
15 interfere with the object for which a special fund was created or
16 any transfer from the Central Valley Water Project Construction
17 Fund, the Central Valley Water Project Revenue Fund, or the
18 California Water Resources Development Bond Fund.

19 (b) (1) Interest shall be paid on all moneys transferred to the
20 General Fund from the following funds:

21 (A) The Department of Food and Agriculture Fund.

22 (B) The DNA Identification Fund.

23 (C) The ~~Mental~~ *Behavioral* Health Services Fund.

24 (D) All funds created pursuant to the California Children and
25 Families Act of 1998, enacted by Proposition 10 at the November
26 3, 1998, statewide general election.

27 (E) Any funds retained by or in the possession of the California
28 Exposition and State Fair pursuant to this section.

29 (2) With respect to all other funds, and unless otherwise
30 specified, if the total moneys transferred to the General Fund in
31 any fiscal year from any special fund pursuant to this section
32 exceed an amount equal to 10 percent of the total additions to
33 surplus available for appropriation as shown in the statement of
34 operations of a prior fiscal year as set forth in the most recent
35 published annual report of the Controller, interest shall be paid on
36 the excess. Interest payable under this section shall be computed
37 at a rate determined by the Pooled Money Investment Board to be
38 the current earning rate of the fund from which transferred.

1 (c) Notwithstanding any other provision of law, except as
2 described in subdivision (d), all moneys in the State Treasury may
3 be loaned for the purposes described in subdivision (a).

4 (d) Subdivision (c) shall not apply to any of the following:

5 (1) The Local Agency Investment Fund.

6 (2) Funds classified in the State of California Uniform Codes
7 Manual as bond funds or retirement funds.

8 (3) All or part of the moneys not needed in other funds or
9 accounts for purposes of subdivision (a) where the Controller is
10 prohibited by the California Constitution, bond indenture, or case
11 law from transferring all or any part of those moneys.

12 *SEC. 4. Section 30026.5 of the Government Code is amended*
13 *to read:*

14 30026.5. (a) “2011 Realignment Legislation” means legislation
15 enacted on or before September 30, 2012, to implement the state
16 budget plan, that is entitled 2011 Realignment and provides for
17 the assignment to local agencies of responsibilities for Public
18 Safety Services, including related reporting responsibilities. The
19 2011 Realignment Legislation shall provide local agencies with
20 maximum flexibility and control over the design, administration,
21 and delivery of those services consistent with federal law and
22 funding requirements, as determined by the Legislature. However,
23 the 2011 Realignment Legislation shall include no new programs
24 assigned to local agencies after January 1, 2012, except for the
25 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
26 program and mental health managed care, which may also be
27 referred to as specialty mental health care services.

28 (b) Any mandate of a new program or higher level of service
29 on a local agency imposed by the 2011 Realignment Legislation,
30 or by any regulation adopted or any executive order or
31 administrative directive issued to implement that legislation, shall,
32 if it constitutes a mandate requiring the state to provide a
33 subvention of funds within the meaning of the California
34 Constitution, be paid from the moneys provided for that activity.

35 (1) A reimbursable mandate for any program or increased level
36 of service initially created by the 2011 Realignment Legislation,
37 as defined in subdivision (a), that may be funded from the
38 Protective Services Subaccount or the Behavioral Health
39 Subaccount or funding received from the Protective Services
40 Growth Special Account or the Behavioral Health Services Growth

1 Special Account shall be paid from the applicable subaccount, and
2 no other funding shall be required unless the total amount received
3 into the subaccount of any county, including optional reallocation
4 pursuant to subparagraph (A) of paragraph (4) of subdivision (f)
5 of Section 30025, is insufficient to provide funding for any or all
6 mandates funded from that subaccount.

7 (2) A reimbursable mandate for any program or service that
8 may be funded from any of the subaccounts in the Law
9 Enforcement Services Account or funding received from the Law
10 Enforcement Services Growth Subaccount shall be paid from the
11 applicable subaccount, and no other funding shall be required
12 unless the total amount received into the subaccount of any county
13 or city and county is insufficient to provide funding for that
14 mandate.

15 (c) (1) Notwithstanding subdivision (b) or any other provision
16 of law, legislation enacted after September 30, 2012, that has an
17 overall effect of increasing the costs already borne by a local
18 agency for programs or levels of service mandated by the 2011
19 Realignment Legislation shall apply to local agencies only to the
20 extent that the state provides annual funding for the cost increase.
21 Local agencies shall not be obligated to provide programs or levels
22 of service required by legislation described in this paragraph above
23 the level for which funding has been provided.

24 (2) Notwithstanding subdivision (b) or any other provision of
25 law, regulations, executive orders, or administrative directives,
26 implemented after October 9, 2011, that are not necessary to
27 implement the 2011 Realignment Legislation and that have an
28 overall effect of increasing the costs already borne by a local
29 agency for programs or levels of service mandated by the 2011
30 Realignment Legislation, shall apply to local agencies only to the
31 extent that the state provides annual funding for the cost increase.
32 Local agencies shall not be obligated to provide programs or levels
33 of service pursuant to new regulations, executive orders, or
34 administrative directives described in this paragraph above the
35 level for which funding has been provided.

36 (3) Notwithstanding subdivision (b) or any other provision of
37 law, any new program or higher level of service provided by local
38 agencies, as described in paragraphs (1) and (2), above the level
39 for which funding has been provided, shall not require a subvention

1 of funds by the state as those costs incurred at the local level shall
2 be optional.

3 (d) Notwithstanding subdivision (b) or any other provision of
4 law, the state shall not submit to the federal government any plans
5 or waivers, or amendments to those plans or waivers, that have an
6 overall effect of increasing the cost borne by a local agency for
7 programs or levels of service mandated by the 2011 Realignment
8 Legislation, except to the extent that the plans, waivers, or
9 amendments are required by federal law, or the state provides
10 annual funding for the cost increase.

11 (e) (1) Notwithstanding subdivisions (b), (c), and (d) or any
12 other provision of law, the state shall not be required to provide a
13 subvention of funds pursuant to this section for a mandate that is
14 imposed by the state at the request of a local agency or to comply
15 with federal law. Any state funds provided pursuant to subdivision
16 (c) or (d) or this subdivision shall be from funding sources other
17 than those described in subdivision (a) of Section 30025, ad
18 valorem property taxes, or the Social Services Subaccount of the
19 Sales Tax Account of the Local Revenue Fund.

20 (2) For programs described in paragraphs (3), (4), and (5) of
21 subdivision (i) of Section 30025 and included in the 2011
22 Realignment Legislation, if there are subsequent changes in federal
23 statutes or regulations that alter the conditions under which federal
24 matching funds as described in the 2011 Realignment Legislation
25 are obtained, and those changes have the overall effect of increasing
26 the costs incurred by a local agency, the state shall annually provide
27 at least 50 percent of the nonfederal share of those costs as
28 determined by the state.

29 (3) When the state is a party to any complaint brought in a
30 federal judicial or administrative proceeding that involves one or
31 more of the programs described in paragraphs (3), (4), and (5) of
32 subdivision (i) of Section 30025 and included in the 2011
33 Realignment Legislation, and there is a settlement or judicial or
34 administrative order that imposes a cost in the form of a monetary
35 penalty or has the overall effect of increasing the costs already
36 borne by a local agency for programs or levels of service mandated
37 by the 2011 Realignment Legislation, the state shall annually
38 provide at least 50 percent of the nonfederal share of those costs
39 as determined by the state. Payment is not required if the state
40 determines that the settlement or order relates to one or more local

1 agencies failing to perform a ministerial duty, failing to perform
2 a legal obligation in good faith, or acting in a negligent or reckless
3 manner.

4 (4) If the state or a local agency fails to perform a duty or
5 obligation under this section or under the 2011 Realignment
6 Legislation, an appropriate party may seek judicial relief. These
7 proceedings shall have priority over all other civil matters.

8 (5) The funds deposited into a County Local Revenue Fund
9 2011 shall be spent in a manner designed to maintain the state's
10 eligibility for federal matching funds and to ensure compliance by
11 the state with applicable federal standards governing the state's
12 provision of Public Safety Services.

13 (6) The funds deposited into a County Local Revenue Fund
14 2011 shall not be used by local agencies to supplant other funding
15 for Public Safety Services.

16 (f) Any decision of a county or a city and county to eliminate
17 or significantly reduce the levels or types of optional or
18 discretionary behavioral health services, adult protective services,
19 or child welfare services pursuant to Sections 11403.1 and 11403.2
20 of, Chapter 2.3 (commencing with Section 16135) of Part 4 of
21 Division 9 of, Sections 16508.2 and 16508.3 of, Article 4
22 (commencing with Section 16522) of Chapter 5 of Part 4 of
23 Division 9 of, Article 2 (commencing with Section 16525.10) of
24 Chapter 5.3 of Part 4 of Division 9 of, and Section 16605 of, the
25 Welfare and Institutions Code and Section 10609.3 of the Welfare
26 and Institutions Code that the county or city and county is or has
27 previously funded, in whole or in part, from allocations received
28 from the Support Services Account of the Local Revenue Fund
29 2011 may, as a condition of the county or city and county receiving
30 funding, only be made in open session, as an action item, at a duly
31 noticed meeting of the board of supervisors. For the purpose of
32 this subdivision, "significant reduction" shall include a 10-percent
33 reduction in funding in any one year or a cumulative 25-percent
34 reduction over the previous three years.

35 (g) (1) Federal funding has been, and continues to be, provided
36 for Public Safety Services described in the 2011 Realignment
37 Legislation that are funded from the subaccounts within the Health
38 and Human Services Account and its successor, the Support
39 Services Account. Starting in the 2012–13 fiscal year, the state
40 provided an additional source of funding for Specialty Mental

1 Health Services, as described in clause (v) of subparagraph (B) of
2 paragraph (16) of subdivision (f) of Section 30025, from the Local
3 Revenue Fund 2011 in addition to providing funding to local
4 government for mental health services from the Local Revenue
5 Fund and the ~~Mental Behavioral~~ Health Services Fund. Starting
6 in the 2011–12 fiscal year, the state provided funding for other
7 Public Safety Services from the Local Revenue Fund and the Local
8 Revenue Fund 2011.

9 (2) Except as required by subdivisions (c) to (e), inclusive, the
10 state shall not have a share of cost for the Public Safety Services
11 described in the 2011 Realignment Legislation funded from the
12 Local Revenue Fund or the subaccounts within the Health and
13 Human Services Account or its successor, the Support Services
14 Account, in the Local Revenue Fund 2011. Funds for the increased
15 county share of cost shall be provided through the subaccounts in
16 the Health and Human Services Account, and from successors to
17 those subaccounts. Before local entities may spend funds from
18 these subaccounts for any other purpose, these funds shall first be
19 expended for activities and providing services that preserve federal
20 funding and to pay for any state-mandated costs for increased
21 costs, duties, or levels of service as the programs are described in
22 statute enacted on or before September 30, 2012, or regulations,
23 executive orders, or administrative directives implemented prior
24 to October 9, 2011, or those regulations that are not necessary to
25 implement the 2011 Realignment Legislation, or State Plan, or
26 any amendments in effect on June 30, 2012. This funding is
27 specifically intended to be in an amount sufficient to fund the cost
28 of the state mandates.

29 (3) Prior to a county electing to use any of its own funds to pay
30 for an increased cost, duty, or level of service above that required
31 by the 2011 Realignment Legislation, or that is optional under the
32 2011 Realignment Legislation, the county shall first exhaust the
33 funding available to it from the Local Revenue Fund established
34 pursuant to Section 17600 of the Welfare and Institutions Code
35 and the Local Revenue Fund 2011 for state-mandated costs, duties,
36 and levels of service.

37 (h) (1) Federal funding has been, and continues to be, provided
38 for Public Safety Services described in the 2011 Realignment
39 Legislation that are funded from the subaccounts within the Health
40 and Human Services Account and its successor, the Support

1 Services Account. Starting in the 2012–13 fiscal year, the state
2 provided an additional source of funding for Specialty Mental
3 Health Services, as described in clause (v) of subparagraph (B) of
4 paragraph (16) of subdivision (f) of Section 30025, from the Local
5 Revenue Fund 2011 in addition to providing funding to local
6 government for mental health services from the Local Revenue
7 Fund and the ~~Mental~~ Behavioral Health Services Fund. Starting
8 in the 2011–12 fiscal year, the state provided funding for other
9 Public Safety Services from the Local Revenue Fund and the Local
10 Revenue Fund 2011.

11 (2) Except as required by subdivisions (c) to (e), inclusive, the
12 state shall not have a share of cost for the health and human
13 services programs described in the 2011 Realignment Legislation
14 funded from the Local Revenue Fund established pursuant to
15 Section 17600 of the Welfare and Institutions Code or the
16 subaccounts within the Health and Human Services Account, or
17 its successor, the Support Services Account, in the Local Revenue
18 Fund 2011. Funds for the increased county share of cost shall be
19 provided through the subaccounts of the Health and Human
20 Services Account and its successors within the Support Services
21 Account.

22 (3) This subdivision shall become operative on November 7,
23 2012, if a constitutional amendment adding Section 36 to Article
24 XIII of the California Constitution is approved by the voters at the
25 November 6, 2012, statewide general election.

26 (i) (1) Every month, the Controller shall post on the Controller’s
27 ~~Internet Web site~~, *internet website* the amount received by the
28 Local Revenue Fund 2011 from revenues raised by Sections
29 6051.15, 6201.15, 11001.5, and 11005 of the Revenue and Taxation
30 Code. Additionally, every month, the Controller shall post the
31 amounts allocated to every account, subaccount, and special
32 account in the Local Revenue Fund 2011.

33 (2) Annually, the Controller shall post on the Controller’s
34 ~~Internet Web site~~ *internet website* the amounts allocated to each
35 account, subaccount, and special account, and provide detailed
36 information as to the source of that funding. The Controller shall
37 also post the highest amount ever allocated to the Behavioral Health
38 Subaccount, the Protective Services Subaccount, the Trial Court
39 Security Subaccount, and the Juvenile Justice Subaccount, and,
40 after the 2014–15 fiscal year, the highest amount ever allocated

1 to the Community Corrections Subaccount, and the District
2 Attorney and Public Defender Subaccount. In every fiscal year in
3 which funding is not at the highest level for subaccounts
4 specifically named in this paragraph, the Controller shall note how
5 much growth funding may need to be provided as restoration
6 funding in a future fiscal year to achieve that level.

7 (3) Annually, the Controller shall post on the Controller's
8 ~~Internet Web site~~ *internet website* the amount each county received
9 pursuant to paragraph (1) of subdivision (a), paragraph (2) of
10 subdivision (b), and paragraph (2) of subdivision (c) of Section
11 30027.9 for each of the county's or city and county's subaccounts.

12 (j) The enactment of the 2011 Realignment Legislation is not
13 intended to, nor does it in any way, affect rights provided by federal
14 entitlement programs. Nothing in the 2011 Realignment Legislation
15 places any additional restrictions on eligibility, coverage, or access
16 to services and care for any federal or state entitlement program.

17 (k) Counties, cities, and city and counties shall fund Medi-Cal
18 Specialty Mental Health Services, including Early and Periodic
19 Screening, Diagnosis and Treatment (EPSDT), from moneys
20 received from the Behavioral Health Subaccount and the
21 Behavioral Health Growth Special Account, both created pursuant
22 to Section 30025, the Mental Health Subaccount created pursuant
23 to Section 17600 of the Welfare and Institutions Code, the Mental
24 Health Account created pursuant to Section 17600.10 of the
25 Welfare and Institutions Code, and to the extent permissible under
26 the Mental Health Services Act, the ~~Mental~~ *Behavioral* Health
27 Services Fund created pursuant to Section 19602.5 of the Revenue
28 and Taxation Code. Because this is a federal entitlement program,
29 the provision of services shall be based on statute, regulation, the
30 managed care waiver provisions of Title XIX of the federal Social
31 Security Act (42 U.S.C. Sec. 1396n), or the State Plan or its
32 amendment or amendments.

33 (l) Subdivisions (a), (b), and (g) shall become inoperative on
34 November 7, 2012, if a constitutional amendment adding Section
35 36 to Article XIII of the California Constitution is approved by
36 the voters at the November 6, 2012, statewide general election.

37 *SEC. 5. Section 100520.5 of the Government Code is amended*
38 *to read:*

39 100520.5. (a) The Health Care Affordability Reserve Fund is
40 hereby created in the State Treasury.

1 (b) Notwithstanding any other law, the Controller may use the
2 funds in the Health Care Affordability Reserve Fund for cashflow
3 loans to the General Fund as provided in Sections 16310 and
4 16381.

5 (c) Upon the enactment of the Budget Act of 2021, and upon
6 order of the Director of Finance, the Controller shall transfer three
7 hundred thirty-three million four hundred thirty-nine thousand
8 dollars (\$333,439,000) from the General Fund to the Health Care
9 Affordability Reserve Fund.

10 (d) Upon appropriation by the Legislature, the Health Care
11 Affordability Reserve Fund shall be utilized, in addition to any
12 other appropriations made by the Legislature for the same purpose,
13 for the purpose of health care affordability programs operated by
14 the California Health Benefit Exchange.

15 (e) (1) The California Health Benefit Exchange shall, in
16 consultation with stakeholders and the Legislature, develop options
17 for providing cost sharing reduction subsidies to reduce cost
18 sharing for low- and middle-income Californians. On or before
19 January 1, 2022, the Exchange shall report those developed options
20 to the Legislature, Governor, and the Healthy California for All
21 Commission, established pursuant to Section 1001 of the Health
22 and Safety Code, for consideration in the 2022–23 budget process.

23 (2) In developing the options, the Exchange shall do all of the
24 following:

25 (A) Include options for all Covered California enrollees with
26 income up to 400 percent of the federal poverty level to reduce
27 cost sharing, including copays, deductibles, coinsurance, and
28 maximum out-of-pocket costs.

29 (B) Include options to provide zero deductibles for all Covered
30 California enrollees with income under 400 percent of the federal
31 poverty level and upgrading those with income between 200
32 percent and 400 percent, inclusive, of the federal poverty level to
33 gold-tier cost sharing.

34 (C) Address any operational issues that might impede
35 implementation of enhanced cost-sharing reductions for the 2023
36 calendar year.

37 (D) Maximize federal funding and address interactions with
38 federal law regarding federal cost-sharing reduction subsidies.

39 (3) The Exchange shall make the report publicly available on
40 its internet website.

1 (4) The Exchange shall submit the report in compliance with
2 Section 9795 of the Government Code.

3 (f) Upon order of the Department of Finance, a loan of six
4 hundred million dollars (\$600,000,000) is authorized from the
5 Health Care Affordability Reserve Fund to the General Fund in
6 the 2023–24 fiscal year. The loan shall be repaid ~~in the 2025–26~~
7 ~~fiscal year.~~ *annual installments of two hundred million dollars*
8 *(\$200,000,000) over the 2026–27, 2027–28, and 2028–29 fiscal*
9 *years.*

10 *SEC. 6. Section 1212 of the Health and Safety Code is amended*
11 *to read:*

12 1212. (a) Any person, firm, association, partnership, or
13 corporation desiring a license for a clinic or a special permit for
14 special services under the provisions of this chapter, shall file with
15 the department a verified application on forms prescribed and
16 furnished by the department, containing the following:

17 (1) Evidence satisfactory to the department that the applicant
18 is of reputable and responsible character. If the applicant is a firm,
19 association, partnership, trust, corporation, or other artificial or
20 legal entity, like evidence shall be submitted as to the members,
21 partners, trustees or shareholders, directors, and officers thereof
22 and as to the person who is to be the administrator of, and exercise
23 control, management, and direction of the clinic for which
24 application is made.

25 (2) If the applicant is a partnership, the name and principal
26 business address of each partner, and, if any partner is a
27 corporation, the name and principal business address of each officer
28 and director of the corporation and name and business address of
29 each stockholder owning 10 percent or more of the stock thereof.

30 (3) If the applicant is a corporation, the name and principal
31 business address of each officer and director of the corporation,
32 and if the applicant is a stock corporation, the name and principal
33 business address of each stockholder holding 10 percent or more
34 of the applicant’s stock and, if any stockholder is a corporation,
35 the name and principal business address of each officer and director
36 of the corporate stockholder.

37 (4) Evidence satisfactory to the department of the ability of the
38 applicant to comply with the provisions of this chapter and rules
39 and regulations promulgated under this chapter by the department.

1 (5) The name and address of the clinic, and if the applicant is
2 a professional corporation, firm, partnership, or other form of
3 organization, evidence that the applicant has complied with the
4 requirements of the Business and Professions Code governing the
5 use of fictitious names by practitioners of the healing arts.

6 (6) The name and address of the professional licentiate
7 responsible for the professional activities of the clinic and the
8 licentiate's license number and professional experience.

9 (7) The class of clinic to be operated, the character and scope
10 of advice and treatment to be provided, and a complete description
11 of the building, its location, facilities, equipment, apparatus, and
12 appliances to be furnished and used in the operation of the clinic.

13 (8) Sufficient operational data to allow the department to
14 determine the class of clinic that the applicant proposes to operate
15 and the initial license fee to be charged.

16 (9) Any other information as may be required by the department
17 for the proper administration and enforcement of this chapter,
18 including, but not limited to, evidence that the clinic has a written
19 policy relating to the dissemination of the following information
20 to patients:

21 (A) A summary of current state laws requiring child passenger
22 restraint systems to be used when transporting children in motor
23 vehicles.

24 (B) A listing of child passenger restraint system programs
25 located within the county, as required by Section 27360 or 27362
26 of the Vehicle Code.

27 (C) Information describing the risks of death or serious injury
28 associated with the failure to utilize a child passenger restraint
29 system.

30 *(10) The information required pursuant to this section shall be*
31 *provided to the Licensing and Certification Program upon initial*
32 *application for licensure. Unless otherwise specified, any change*
33 *in the information that requires the licensee to submit a report of*
34 *change or written notification to the Licensing and Certification*
35 *Program shall be provided within 10 business days of the change*
36 *along with any applicable fee according to subdivision (b) of*
37 *Section 1266.*

38 (b) (1) No application is required if a licensed primary care
39 clinic adds a service that is not a special service, as defined in
40 Section 1203, or any regulation adopted under that section, or

1 remodels or modifies, or adds an additional physical plant
2 maintained and operated on separate premises to, an existing
3 primary care clinic site. However, the clinic shall notify the
4 department, in writing, of the change in service or physical plant
5 no less than 60 days prior to adding the service or remodeling or
6 modifying, or adding an additional physical plant maintained and
7 operated on a separate premises to, an existing primary care clinic
8 site. Nothing in this subdivision shall be construed to limit the
9 authority of the department to conduct an inspection at any time
10 pursuant to Section 1227, in order to ensure compliance with, or
11 to prevent a violation of, this chapter, or any regulation adopted
12 under this chapter.

13 (2) If applicable city, county, or state law obligates the primary
14 care clinic to obtain a building permit with respect to the
15 remodeling or modification to be performed by the clinic, or the
16 construction of a new physical plant, the primary care clinic shall
17 provide a signed certification or statement as described in Section
18 1226.3 to the department within 60 days following completion of
19 the remodeling, modification, or construction project covered by
20 the building permit.

21 (c) In the course of fulfilling its obligations under Section
22 1221.09, the department shall ensure that any application form
23 utilized by a primary care clinic, requiring information of the type
24 specified in paragraph (1), (4), (8), or (9) of subdivision (a), is
25 consistent with the requirements of Section 1225, including the
26 requirement that rules and regulations for primary care clinics be
27 separate and distinct from the rules and regulations for specialty
28 clinics. Nothing in this section shall be construed to require the
29 department to issue a separate application form for primary care
30 clinics.

31 (d) (1) The department, upon written notification by a primary
32 care clinic or an affiliate clinic of its intent to add an additional
33 physical plant maintained and operated on separate premises, as
34 described in paragraph (1) of subdivision (b) and upon payment
35 of a licensing fee for each additional physical plant added, shall
36 review the information provided in the notification, and if the
37 information submitted is in compliance with the requirements
38 specified in this subdivision, the department shall approve the
39 additional physical plant within 30 days of all information being
40 submitted and shall amend the primary care clinic or affiliate

1 clinic’s license to include the additional physical plant as part of
2 a single consolidated license. If the notification does not include
3 the information required by this subdivision, the department shall
4 notify the licensee of the need for additional information and shall
5 not amend the license to add the additional physical plant until the
6 additional information is received and reviewed by the department.

7 (2) Written notification shall include evidence that the primary
8 care clinic or affiliate clinic is licensed in good standing and
9 otherwise meets the criteria specified in this subdivision. In issuing
10 the single consolidated license, the department shall specify the
11 location of each physical plant.

12 (3) The written notification shall demonstrate compliance with
13 all of the following criteria:

14 (A) There is a single governing body for all the facilities
15 maintained and operated by the licensee.

16 (B) There is a single administration for all the facilities
17 maintained and operated by the licensee.

18 (C) There is a single medical director for all the facilities
19 maintained and operated by the licensee, with a single set of
20 bylaws, rules, and regulations.

21 (D) The additional physical plant meets minimum construction
22 standards of adequacy and safety for clinics found in the most
23 recent version of the California Building Standards Code and
24 prescribed by the Office of Statewide Health Planning and
25 Development, as required in subdivision (b) of Section 1226.
26 Compliance with the minimum construction standards of adequacy
27 and safety may be established as specified in Section 1226.3.

28 (E) The additional physical plant meets fire clearance standards.

29 (4) The written notification required to be submitted pursuant
30 to this subdivision shall include all of the following documentation:

31 (A) The name and address of the licensee’s corporation
32 administrative office, including the name and contact information
33 for the corporation’s chief executive officer or executive director.

34 (B) The name and address of, and the hours of operation and
35 services provided by, the additional physical plant.

36 (C) A copy of any document confirming the corporation’s
37 authority to control the additional physical plant. Examples of
38 acceptable documentation include, but shall not be limited to, a
39 lease or purchase agreement, grant deed, bill of sale, sublease,

1 rental agreement, or memorandum of understanding between the
2 owner of the property and the proposed licensee.

3 (5) A primary care clinic or an affiliate clinic may add additional
4 physical plants pursuant to this section that are no more than
5 one-half mile from the licensed clinic adding the additional
6 physical plant under a consolidated license.

7 (6) Upon renewal of a consolidated license approved pursuant
8 to this subdivision, a licensee fee shall be required for each
9 additional physical plant approved on the license.

10 *SEC. 7. Section 1214 of the Health and Safety Code is amended*
11 *to read:*

12 1214. Each application under this chapter for an initial license,
13 renewal license, license upon change of ownership, or special
14 permit shall be accompanied by a Licensing and Certification
15 Program fee, as follows:

16 (a) For all primary care clinics licensed pursuant to this chapter,
17 the ~~annual~~ fee shall be set in accordance with Section 1266.

18 (b) For all specialty clinics licensed pursuant to this chapter,
19 the ~~annual~~ fee shall be set in accordance with Section 1266.

20 (c) For all rehabilitation clinics, the ~~annual~~ fee shall be set in
21 accordance with Section 1266.

22 *SEC. 8. Section 1214.1 of the Health and Safety Code is*
23 *amended to read:*

24 1214.1. Notwithstanding the provisions of Section 1214, each
25 application for a surgical clinic or a chronic dialysis clinic under
26 this chapter for an initial license, renewal license, license upon
27 change of ownership, or special permit shall be accompanied by
28 ~~an annual~~ a Licensing and Certification Program fee set in
29 accordance with Section 1266.

30 *SEC. 9. Section 1266 of the Health and Safety Code is amended*
31 *to read:*

32 1266. (a) The Licensing and Certification ~~Division~~ *Program*
33 shall be supported entirely by federal funds and special funds by
34 no earlier than the beginning of the 2009–10 fiscal year unless
35 otherwise specified in statute, or unless funds are specifically
36 appropriated from the General Fund in the annual Budget Act or
37 other enacted legislation. ~~For the 2007–08 fiscal year, General~~
38 ~~Fund support shall be provided to offset licensing and certification~~
39 ~~fees in an amount of not less than two million seven hundred~~
40 ~~eighty-two thousand dollars (\$2,782,000).~~

1 (b) (1) The Licensing and Certification Program fees for the
2 2006-07 fiscal year shall be as follows:

3	Type of Facility	Fee	
4	General Acute Care Hospitals	\$ 134.10	per bed
5	Acute Psychiatric Hospitals	\$ 134.10	per bed
6	Special Hospitals	\$ 134.10	per bed
7	Chemical Dependency Recovery Hospitals	\$ 123.52	per bed
8	Skilled Nursing Facilities	\$ 202.96	per bed
9	Intermediate Care Facilities	\$ 202.96	per bed
10	Intermediate Care Facilities-Developmentally 11 Disabled	\$ 592.29	per bed
12	Intermediate Care Facilities-Developmentally 13 Disabled-Habilitative	\$1,000.00	per facility
14	Intermediate Care Facilities-Developmentally 15 Disabled-Nursing	\$1,000.00	per facility
16	Home Health Agencies	\$2,700.00	per facility
17	Referral Agencies	\$5,537.71	per facility
18	Adult Day Health Centers	\$4,650.02	per facility
19	Congregate Living Health Facilities	\$ 202.96	per bed
20	Psychology Clinics	\$ 600.00	per facility
21	Primary Clinics- Community and Free	\$ 600.00	per facility
22	Specialty Clinics- Rehab Clinics		
23	—(For profit)	\$2,974.43	per facility
24	—(Nonprofit)	\$ 500.00	per facility
25	Specialty Clinics- Surgical and Chronic	\$1,500.00	per facility
26	Dialysis Clinics	\$1,500.00	per facility
27	Pediatric Day Health/Respite Care	\$ 142.43	per bed
28	Alternative Birthing Centers	\$2,437.86	per facility
29	Hospice	\$1,000.00	per provider
30	Correctional Treatment Centers	\$ 590.39	per bed
31			
32			

33 (2) (A) In the first year of licensure for intermediate care
34 facility/developmentally disabled-continuous nursing (ICF/DD-CN)
35 facilities, the licensure fee for those facilities shall be equivalent
36 to the licensure fee for intermediate care facility/developmentally
37 disabled-nursing facilities during the same year. Thereafter, the
38 licensure fee for ICF/DD-CN facilities shall be established pursuant
39 to the same procedures described in this section.

1 ~~(B) In the first year of licensure for hospice facilities, the~~
 2 ~~licensure fee shall be equivalent to the licensure fee for congregate~~
 3 ~~living health facilities during the same year. Thereafter, the~~
 4 ~~licensure fee for hospice facilities shall be established pursuant to~~
 5 ~~the same procedures described in this section.~~

6 ~~(e) Commencing in the 2015–16 fiscal year, the fees for skilled~~
 7 ~~nursing facilities shall be increased so as to generate four hundred~~
 8 ~~thousand dollars (\$400,000) for the California Department of~~
 9 ~~Aging’s Long-Term Care Ombudsman Program for its work related~~
 10 ~~to investigating complaints made against skilled nursing facilities~~
 11 ~~and increasing visits to those facilities.~~

12 ~~(d)~~

13 ~~(b) Commencing February 1, 2007, and every February 1~~
 14 ~~thereafter, the department *Licensing and Certification Program*~~
 15 ~~shall publish a list of estimated fees *program fees, including, but*~~
 16 ~~*not limited to, annual licensing, report of change application, and*~~
 17 ~~*written notification fees* pursuant to this section. The calculation~~
 18 ~~of estimated fees and the publication of the report and list of~~
 19 ~~estimated fees shall not be subject to the rulemaking requirements~~
 20 ~~of Chapter 3.5 (commencing with Section 11340) of Part 1 of~~
 21 ~~Division 3 of Title 2 of the Government Code.~~

22 ~~(e)~~

23 ~~(c) Notwithstanding Section 10231.5 of the Government Code,~~
 24 ~~by February 1 of each year, the department shall prepare the~~
 25 ~~following reports and shall make those reports, and the list of~~
 26 ~~estimated fees required to be published pursuant to subdivision~~
 27 ~~~~(d)~~, *(b)*, available to the public by submitting them to the~~
 28 ~~Legislature and posting them on the department’s ~~Internet Web~~~~
 29 ~~~~site~~: *internet website*:~~

30 ~~(1) A report of all costs for activities of the Licensing and~~
 31 ~~Certification Program. At a minimum, this report shall include a~~
 32 ~~narrative of all baseline adjustments and their calculations, a~~
 33 ~~description of how each category of facility was calculated,~~
 34 ~~descriptions of assumptions used in any calculations, and shall~~
 35 ~~recommend Licensing and Certification Program fees in accordance~~
 36 ~~with the following:~~

37 ~~(A) Projected workload and costs shall be grouped for each fee~~
 38 ~~category, including workload costs for facility categories that have~~
 39 ~~been established by statute and for which licensing regulations~~
 40 ~~and procedures are under development.~~

1 (B) Cost estimates, and the estimated fees, shall be based on
2 the appropriation amounts in the Governor’s proposed budget for
3 the next fiscal year, with and without policy adjustments to the fee
4 methodology.

5 (C) The allocation of program, operational, and administrative
6 overhead, and indirect costs to fee categories shall be based on
7 generally accepted cost allocation methods. Significant items of
8 costs shall be directly charged to fee categories if the expenses can
9 be reasonably identified to the fee category that caused them.
10 Indirect and overhead costs shall be allocated to all fee categories
11 using a generally accepted cost allocation method.

12 (D) The amount of federal funds and General Fund moneys to
13 be received in the budget year shall be estimated and allocated to
14 each fee category based upon an appropriate metric.

15 (E) The fee for each category shall be determined by dividing
16 the aggregate state share of all costs for the Licensing and
17 Certification Program by the appropriate metric for the category
18 of licensure. Amounts—~~actually~~ received for new licensure
19 applications, including change of ownership applications, and late
20 payment penalties, pursuant to Section 1266.5, during each fiscal
21 year shall be calculated and 95 percent shall be applied to the
22 appropriate fee categories in determining Licensing and
23 Certification Program fees for the second fiscal year following
24 receipt of those funds. The remaining 5 percent shall be retained
25 in the fund as a reserve until appropriated.

26 (2) (A) A staffing and systems analysis to ensure efficient and
27 effective utilization of fees collected, proper allocation of
28 departmental resources to licensing and certification activities,
29 survey schedules, complaint investigations, enforcement and appeal
30 activities, data collection and dissemination, surveyor training,
31 and policy development.

32 (B) The analysis under this paragraph shall be made available
33 to interested persons and shall include all of the following:

34 (i) The number of surveyors and administrative support
35 personnel devoted to the licensing and certification of health care
36 facilities.

37 (ii) The percentage of time devoted to licensing and certification
38 activities for the various types of health facilities.

39 (iii) The number of facilities receiving full surveys and the
40 frequency and number of followup visits.

1 (iv) The number and timeliness of complaint investigations,
 2 including data on the department's compliance with the
 3 requirements of paragraphs (3), (4), and (5) of subdivision (a) of
 4 Section 1420.

5 (v) Data on deficiencies and citations issued, and numbers of
 6 ~~citation review conferences and arbitration hearings.~~

7 (vi) Other applicable activities of the ~~licensing and certification~~
 8 ~~division~~. *Licensing and Certification Program.*

9 (3) The annual program fee report described in subdivision (d)
 10 of Section 1416.36.

11 ~~(f)~~

12 (d) The reports required pursuant to subdivision ~~(e)~~ (c) shall be
 13 submitted in compliance with Section 9795 of the Government
 14 Code.

15 (e) *Commencing in the 2015–16 fiscal year, the fees for skilled*
 16 *nursing facilities shall be increased so as to generate four hundred*
 17 *thousand dollars (\$400,000) for the California Department of*
 18 *Aging's Long-Term Care Ombudsman Program for its work related*
 19 *to investigating complaints made against skilled nursing facilities*
 20 *and increasing visits to those facilities.*

21 ~~(g)~~

22 (f) Commencing in the 2018–19 fiscal year, the ~~department~~
 23 *Licensing and Certification Program* may assess a supplemental
 24 ~~license program~~ fee on facilities located in the County of Los
 25 Angeles for all facility types set forth in this section. This
 26 supplemental ~~license program~~ fee shall be in addition to the ~~license~~
 27 *program* fees set forth in *the estimated program fee list described*
 28 *in subdivision ~~(d)~~ (b).* The ~~department~~ *Licensing and Certification*
 29 *Program* shall calculate the supplemental ~~license program~~ fee
 30 based upon the difference between the estimated costs of regulating
 31 facility types licensed in the County of Los Angeles, including,
 32 but not limited to, the costs associated with the ~~department's~~
 33 *Licensing and Certification Program's* contract for licensing and
 34 certification activities with the County of Los Angeles and the
 35 costs of the ~~department~~ *Licensing and Certification Program*
 36 conducting the licensing and certification activities for facilities
 37 located in the County of Los Angeles. The supplemental ~~license~~
 38 *program* fees shall be used to cover the costs to administer and
 39 enforce state licensure standards and other federal compliance
 40 activities for facilities located in the County of Los Angeles, as

1 described in the annual report. The supplemental ~~license~~ *program*
2 fee shall be based upon the fee methodology published in the
3 annual report described in subdivision ~~(d)~~. *(b)*.

4 ~~(h)~~

5 *(g)* (1) The ~~department~~ *Licensing and Certification Program*
6 shall adjust the list of estimated fees published pursuant to
7 subdivision ~~(d)~~ *(b)* if the annual Budget Act or other enacted
8 legislation includes an appropriation that differs from those
9 proposed in the Governor's proposed budget for that fiscal year.

10 (2) The ~~department~~ *Licensing and Certification Program* shall
11 publish a final fee list, with an explanation of any adjustment, by
12 the issuance of an all facilities letter, by posting the list on the
13 department's ~~Internet Web site~~, *internet website*, and by including
14 the final fee list as part of the licensing application package, within
15 14 days of the enactment of the annual Budget Act. The adjustment
16 of fees and the publication of the final fee list shall not be subject
17 to the rulemaking requirements of Chapter 3.5 (commencing with
18 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
19 Code.

20 ~~(i)~~ ~~(1)~~

21 *(h)* Fees shall not be assessed or collected pursuant to this
22 section from any state department, authority, bureau, commission,
23 or officer, unless federal financial participation would become
24 available by doing so and an appropriation is included in the annual
25 Budget Act for that state department, authority, bureau,
26 commission, or officer for this purpose. Fees shall not be assessed
27 or collected pursuant to this section from any clinic that is certified
28 only by the federal government and is exempt from licensure under
29 Section 1206, unless federal financial participation would become
30 available by doing so.

31 ~~(2) For the 2006-07 state fiscal year, a fee shall not be assessed~~
32 ~~or collected pursuant to this section from any general acute care~~
33 ~~hospital owned by a health care district with 100 beds or less.~~

34 ~~(j)~~

35 *(i)* The Licensing and Certification Program may change annual
36 license expiration renewal dates to provide for efficiencies in
37 operational processes or to provide for sufficient cashflow to pay
38 for expenditures. If an annual license expiration date is changed,
39 the ~~renewal~~ *annual license* fee shall be prorated accordingly.
40 Facilities shall be provided with a 60-day notice of any change in

1 their annual license renewal date. *If a licensee voluntarily*
 2 *surrenders its license, they shall not be entitled to a refund for the*
 3 *remainder of the license period.*

4 ~~(k)~~

5 (j) Commencing with the 2018–19 November Program estimate,
 6 the Licensing and Certification Program shall evaluate the
 7 feasibility of reducing investigation timelines based on experience
 8 with implementing paragraphs (3), (4), and (5) of subdivision (a)
 9 of Section 1420.

10 *SEC. 10. Section 1266.5 of the Health and Safety Code is*
 11 *amended to read:*

12 1266.5. (a) Whenever any entity required to pay fees pursuant
 13 to Section 1266 continues to operate beyond its license expiration
 14 date, without the Licensing and Certification Program ~~renewal~~
 15 *annual license* fees first having been paid as required by this
 16 division, those fees are delinquent.

17 (b) A late payment penalty shall be added to any delinquent
 18 ~~fees due with an application for license renewal~~ *annual license*
 19 *fees* made later than midnight of the license expiration date. The
 20 late payment penalty shall be computed as follows:

21 (1) For a delinquency period of 30 days or less, the penalty shall
 22 be 10 percent of the fee.

23 (2) For a delinquency period of more than 30 days to and
 24 including 60 days, the penalty shall be 20 percent of the fee.

25 (3) For a delinquency period of more than 60 days, the penalty
 26 shall be 60 percent of the fee.

27 ~~(e) The department may, upon written notification to the~~
 28 ~~licensee, offset any moneys owed to the licensee by the Medi-Cal~~
 29 ~~program or any other payment program administered by the~~
 30 ~~department, to recoup the license renewal fee and any associated~~
 31 ~~late payment penalties.~~

32 ~~(d) No license may~~

33 (c) A license may not be renewed without payment of the
 34 Licensing and Certification Program *annual license* fee plus any
 35 late payment penalty.

36 (d) *Whenever any entity required to pay a report of change or*
 37 *written notification fee pursuant to Section 1266 fails to both*
 38 *submit a timely report of change or written notification and pay*
 39 *the applicable fee, those fees are delinquent.*

1 (e) A late payment penalty shall be added to any delinquent fees
2 due with a report of change or written notification made later than
3 midnight of the required submission date. The late payment penalty
4 shall be computed as follows:

5 (1) For a delinquency period of 30 days or less, the penalty
6 shall be 10 percent of the fee.

7 (2) For a delinquency period of more than 30 days to and
8 including 60 days, the penalty shall be 20 percent of the fee.

9 (3) For a delinquency period of more than 60 days, the penalty
10 shall be 60 percent of the fee.

11 (f) The Licensing and Certification Program may, upon written
12 notification to the licensee, offset any moneys owed to the licensee
13 by the Medi-Cal program or any other payment program
14 administered by the department to recoup any annual license,
15 report of change, or written notification fee along with any
16 associated late payment penalties.

17 SEC. 11. Section 1341.45 of the Health and Safety Code is
18 amended to read:

19 1341.45. (a) There is hereby created in the State Treasury the
20 Managed Care Administrative Fines and Penalties Fund.

21 (b) The fines and administrative penalties collected pursuant to
22 this chapter, on and after September 30, 2008, shall be deposited
23 into the Managed Care Administrative Fines and Penalties Fund.

24 (c) The fines and administrative penalties deposited into the
25 Managed Care Administrative Fines and Penalties Fund shall be
26 transferred by the department, beginning September 1, 2009, and
27 annually thereafter, as follows:

28 (1) The first one million dollars (\$1,000,000) shall be transferred
29 to the Medically Underserved Account for Physicians within the
30 Health Professions Education Fund and shall, upon appropriation
31 by the Legislature, be used for the purposes of the Steven M.
32 Thompson Physician Corps Loan Repayment Program, as specified
33 in Article 5 (commencing with Section 128550) or Chapter 5 of
34 Part 3 of Division 107 and, notwithstanding Section 128555, shall
35 not be used to provide funding for the Physician Volunteer
36 Program.

37 (2) Any amount over the first one million dollars (\$1,000,000),
38 including accrued interest, in the fund shall be transferred to the
39 Health Care Services Plan Fines and Penalties Fund created
40 pursuant to Section 15893 of the Welfare and Institutions Code

1 and, notwithstanding Section 13340 of the Government Code, shall
2 be continuously appropriated for the purposes specified in Section
3 15894 of the Welfare and Institutions Code.

4 (d) Notwithstanding subdivision (b) of Section 1356 and Section
5 1356.1, the fines and administrative penalties authorized pursuant
6 to this chapter shall not be used to reduce the assessments imposed
7 on health care service plans pursuant to Section 1356.

8 (e) The amendments made to this section by the act adding this
9 subdivision shall become operative on July 1, 2014.

10 (f) The amendments made to this section by the act adding this
11 subdivision shall become operative on July 1, 2017.

12 *SEC. 12. Section 1389.25 of the Health and Safety Code is*
13 *amended to read:*

14 1389.25. (a) (1) This section shall apply only to a full service
15 health care service plan offering health coverage in the individual
16 market in California and shall not apply to a specialized health
17 care service plan, a health care service plan contract in the
18 Medi-Cal program (Chapter 7 (commencing with Section 14000)
19 of Part 3 of Division 9 of the Welfare and Institutions Code), a
20 health care service plan conversion contract offered pursuant to
21 Section 1373.6, a health care service plan contract in the Healthy
22 Families Program (Part 6.2 (commencing with Section 12693) of
23 Division 2 of the Insurance Code), or a health care service plan
24 contract offered to a federally eligible defined individual under
25 Article 4.6 (commencing with Section 1366.35).

26 (2) A local initiative, as defined in subdivision (w) of Section
27 53810 of Title 22 of the California Code of Regulations, that is
28 awarded a contract by the State Department of Health Care Services
29 pursuant to subdivision (b) of Section 53800 of Title 22 of the
30 California Code of Regulations, shall not be subject to this section
31 unless the plan offers coverage in the individual market to persons
32 not covered by Medi-Cal or the Healthy Families Program.

33 (b) (1) No change in the premium rate or coverage for an
34 individual plan contract shall become effective unless the plan has
35 provided a written notice of the change at least 10 days prior to
36 the start of the annual enrollment period applicable to the contract
37 or 60 days prior to the effective date of the contract renewal,
38 whichever occurs earlier in the calendar year.

39 (2) The written notice required pursuant to paragraph (1) shall
40 be provided to the individual contractholder at ~~his or her~~ *their* last

1 address known to the plan. The notice shall state in italics and in
2 12-point type the actual dollar amount of the premium rate increase
3 and the specific percentage by which the current premium will be
4 increased. The notice shall describe in plain, understandable
5 English any changes in the plan design or any changes in benefits,
6 including a reduction in benefits or changes to waivers, exclusions,
7 or conditions, and highlight this information by printing it in italics.
8 The notice shall specify in a minimum of 10-point bold typeface,
9 the reason for a premium rate change or a change to the plan design
10 or benefits.

11 (c) (1) If the department determines that a rate is unreasonable
12 or not justified consistent with Article 6.2 (commencing with
13 Section 1385.01), the plan shall notify the contractholder of this
14 determination. This notification may be included in the notice
15 required in subdivision (b). The notification to the contractholder
16 shall be developed by the department. The development of the
17 notification required under this subdivision shall not be subject to
18 the Administrative Procedure Act (Chapter 3.5 (commencing with
19 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
20 Code).

21 (2) The notification to the contractholder shall include the
22 following statements in 14-point type:

23 (A) The Department of Managed Health Care has determined
24 that the rate for this product is unreasonable or not justified after
25 reviewing information submitted to it by the plan.

26 (B) During the open enrollment period, the contractholder has
27 the option to obtain other coverage from this plan or another plan,
28 or to keep this coverage.

29 (C) The contractholder may want to contact Covered California
30 at www.coveredca.com for help in understanding available options.

31 (D) Many Californians are eligible for financial assistance from
32 Covered California to help pay for coverage.

33 (3) The plan may include in the notification to the contractholder
34 the ~~Internet Web site~~ *internet website* address at which the plan's
35 final justification for implementing an increase that has been
36 determined to be unreasonable by the director may be found
37 pursuant to Section 154.230 of Title 45 of the Code of Federal
38 Regulations.

1 (4) The notice shall also be provided to the solicitor for the
2 contractholder, if any, so that the solicitor may assist the purchaser
3 in finding other coverage.

4 (5) In developing the notification, the department shall take into
5 consideration that this notice is required to be provided to an
6 individual applicant pursuant to subdivision (g) of Section 1385.03.

7 ~~(d) *Before July 1, 2024, if a plan rejects a dependent of*~~
8 ~~*a subscriber applying to be added to the subscriber's individual*~~
9 ~~*grandfathered health plan, rejects an applicant for a Medicare*~~
10 ~~*supplement plan contract due to the applicant having end-stage*~~
11 ~~*renal disease, or offers an individual grandfathered health plan to*~~
12 ~~*an applicant at a rate that is higher than the standard rate, the plan*~~
13 ~~*shall inform the applicant about the California Major Risk Medical*~~
14 ~~*Insurance Program (MRMIP) (Chapter 4 (commencing with*~~
15 ~~*Section 15870) of Part 3.3 of Division 9 of the Welfare and*~~
16 ~~*Institutions Code) and about the new coverage options and the*~~
17 ~~*potential for subsidized coverage through Covered California. The*~~
18 ~~*plan shall direct persons seeking more information to MRMIP,*~~
19 ~~*Covered California, plan or policy representatives, insurance*~~
20 ~~*agents, or an entity paid by Covered California to assist with health*~~
21 ~~*coverage enrollment, such as a navigator or an assister.*~~

22 *(2) On or after July 1, 2024, if a plan rejects a dependent of a*
23 *subscriber applying to be added to the subscriber's individual*
24 *grandfathered health plan, rejects an applicant for a Medicare*
25 *supplement plan contract due to the applicant having end-stage*
26 *renal disease, or offers an individual grandfathered health plan*
27 *to an applicant at a rate that is higher than the standard rate, the*
28 *plan shall inform the applicant about new coverage options and*
29 *the potential for subsidized coverage through Covered California.*
30 *The plan shall direct persons seeking more information to Covered*
31 *California, plan or policy representatives, insurance agents, or*
32 *an entity paid by Covered California to assist with health coverage*
33 *enrollment, such as a navigator or an assister.*

34 (e) A notice provided pursuant to this section is a private and
35 confidential communication and, at the time of application, the
36 plan shall give the individual applicant the opportunity to designate
37 the address for receipt of the written notice in order to protect the
38 confidentiality of any personal or privileged information.

39 (f) For purposes of this section, the following definitions shall
40 apply:

1 (1) “Covered California” means the California Health Benefit
2 Exchange established pursuant to Section 100500 of the
3 Government Code.

4 (2) “Grandfathered health plan” has the same meaning as that
5 term is defined in Section 1251 of PPACA.

6 (3) “PPACA” means the federal Patient Protection and
7 Affordable Care Act (Public Law 111-148), as amended by the
8 federal Health Care and Education Reconciliation Act of 2010
9 (Public Law 111-152), and any rules, regulations, or guidance
10 issued pursuant to that law.

11 *SEC. 13. Section 1728.1 of the Health and Safety Code is*
12 *amended to read:*

13 1728.1. (a) To qualify for a home health agency license, the
14 following requirements shall be met:

15 (1) Every applicant shall satisfy the following conditions:

16 (A) Be of good moral character. If the applicant is a firm,
17 association, organization, partnership, business trust, corporation,
18 or company, all principal managing members thereof, and the
19 person in charge of the agency for which application for license
20 is made, shall satisfy this requirement. If the applicant is a political
21 subdivision of the state or other governmental agency, the person
22 in charge of the agency for which application for license is made,
23 shall satisfy this requirement.

24 (B) Possess and demonstrate the ability to comply with this
25 chapter and the rules and regulations adopted under this chapter
26 by the state department.

27 (C) File ~~his or her~~ *their* application pursuant to and in full
28 compliance with this chapter.

29 (2) (A) The following persons shall submit to the State
30 Department of Public Health an application and shall submit
31 electronic fingerprint images to the Department of Justice for the
32 furnishing of the person’s criminal record to the state department,
33 at the person’s expense as provided in subdivision (b), for the
34 purpose of a criminal record review:

35 (i) The owner or owners of a private agency if the owners are
36 individuals.

37 (ii) If the owner of a private agency is a corporation, partnership,
38 or association, any person having a 10 percent or greater interest
39 in that corporation, partnership, or association.

40 (iii) The administrator of a home health agency.

1 (B) When the conditions set forth in paragraph (3) of subdivision
2 (a) of Section 1265.5, subparagraph (A) of paragraph (1) of
3 subdivision (a) of Section 1338.5, and paragraph (1) of subdivision
4 (a) of Section 1736.6 are met, the licensing and certification
5 program shall issue an All Facilities Letter (AFL) informing facility
6 licensees. After the AFL is issued, facilities must not allow newly
7 hired administrators, program directors, and fiscal officers to have
8 direct contact with clients or residents of the facility prior to
9 completion of the criminal record clearance. A criminal record
10 clearance shall be complete when the department has obtained the
11 person's criminal offender record information search response
12 from the Department of Justice and has determined that the person
13 is not disqualified from engaging in the activity for which clearance
14 is required.

15 (3) *The information required pursuant to this section shall be*
16 *provided to the Licensing and Certification Program upon initial*
17 *application for licensure. Unless otherwise specified, any change*
18 *in the information that requires the licensee to submit a report of*
19 *change or written notification to the Licensing and Certification*
20 *Program shall be provided within 10 business days of the change*
21 *along with any applicable fee according to subdivision (b) of*
22 *Section 1266.*

23 (b) The persons specified in paragraph (2) of subdivision (a)
24 shall be responsible for any costs associated with transmitting the
25 electronic fingerprint images. The fee to cover the processing costs
26 of the Department of Justice, not including the costs associated
27 with capturing or transmitting the fingerprint images and related
28 information, shall not exceed thirty-two dollars (\$32) per
29 submission.

30 (c) If the criminal record review conducted pursuant to
31 paragraph (2) of subdivision (a) discloses a conviction for a felony
32 or any crime that evidences an unfitness to provide home health
33 services, the application for a license shall be denied or the person
34 shall be prohibited from providing service in the home health
35 agency applying for a license. This subdivision shall not apply to
36 deny a license or prohibit the provision of service if the person
37 presents evidence satisfactory to the state department that the
38 person has been rehabilitated and presently is of such good
39 character as to justify the issuance of the license or the provision
40 of service in the home health agency.

1 (d) An applicant and any other person specified in this section,
2 as part of the background clearance process, shall provide
3 information as to whether or not the person has any prior criminal
4 convictions, has had any arrests within the past 12-month period,
5 or has any active arrests, and shall certify that, to the best of ~~his~~
6 ~~or her~~ *their* knowledge, the information provided is true. This
7 requirement is not intended to duplicate existing requirements for
8 individuals who are required to submit fingerprint images as part
9 of a criminal background clearance process. Every applicant shall
10 provide information on any prior administrative action taken
11 against ~~him or her~~ *them* by any federal, state, or local government
12 agency and shall certify that, to the best of ~~his or her~~ *their*
13 knowledge, the information provided is true. An applicant or other
14 person required to provide information pursuant to this section
15 that knowingly or willfully makes false statements, representations,
16 or omissions may be subject to administrative action, including,
17 but not limited to, denial of ~~his or her~~ *their* application or
18 exemption or revocation of any exemption previously granted.

19 *SEC. 14. Section 1749 of the Health and Safety Code is*
20 *amended to read:*

21 1749. (a) To qualify for a license under this chapter, an
22 applicant shall satisfy all of the following:

23 (1) Be of good moral character. If the applicant is a franchise,
24 franchisee, firm, association, organization, partnership, business
25 trust, corporation, company, political subdivision of the state, or
26 governmental agency, the person in charge of the hospice for which
27 the application for a license is made shall be of good moral
28 character.

29 (2) Demonstrate the ability of the applicant to comply with this
30 chapter and any rules and regulations promulgated under this
31 chapter by the department.

32 (3) File a completed application with the department that was
33 prescribed and furnished pursuant to Section 1748.

34 (4) *The information required pursuant to this section shall be*
35 *provided to the Licensing and Certification Program upon initial*
36 *application for licensure. Unless otherwise specified, any change*
37 *in the information that requires the licensee to submit a report of*
38 *change or written notification to the Licensing and Certification*
39 *Program shall be provided within 10 business days of the change*

1 *along with any applicable fee according to subdivision (b) of*
2 *Section 1266.*

3 (b) (1) A hospice agency shall have an administrator,
4 administrator designee, director of patient care services, director
5 of patient care services designee, and medical director or contracted
6 medical director, and shall submit to the department all of the
7 following information for each individual on an initial application:

8 (A) An HS 215A form or its successor form.

9 (B) A résumé.

10 (C) A list of all hospice agencies the individual is currently
11 serving as an administrator, administrator designee, director of
12 patient care services, director of patient care services designee, or
13 medical director or contracted medical director.

14 (2) In addition to the information required pursuant to paragraph
15 (1), a hospice agency shall submit to the department information
16 on whether its medical director, or contracted medical director, is
17 certified as a hospice medical director according to the
18 requirements established by the Hospice Medical Director
19 Certification Board, or certified in hospice and palliative medicine
20 according to the requirements established by a member board of
21 the American Board of Medical Specialties, or by the American
22 Osteopathic Association, or an equivalent organization as
23 determined by the department.

24 (3) A hospice agency shall notify the department of any change
25 in the administrator, administrator designee, director of patient
26 care services, director of patient care services designee, or medical
27 director or contracted medical director by submitting the
28 information described in paragraphs (1) and (2) within 10 business
29 days of the change.

30 (4) All hospice agencies shall report to the department the name
31 of the agency's administrator, administrator designee, director of
32 patient care services, director of patient care services designee,
33 and medical director or contracted medical director by submitting
34 the information required by paragraphs (1) and (2), no later than
35 March 31, 2023.

36 (c) (1) The department shall verify the status of professional
37 licensure for hospice agency management personnel.

38 (2) The department may also verify the following:

39 (A) Association of hospice agency management personnel listed
40 on the licensing application with the hospice agency.

1 (B) Work history of hospice agency management personnel.

2 (3) For purposes of this subdivision, verification may include
3 contacting the hospice agency personnel or previous employers
4 by telephone.

5 (d) In order for a person, political subdivision of the state, or
6 other governmental agency to be licensed as a hospice agency, it
7 shall satisfy the definition of a hospice contained in Section 1746,
8 and also provide, or make provision for, the following basic
9 services:

10 (1) Skilled nursing services.

11 (2) Social services/counseling services.

12 (3) Medical direction.

13 (4) Bereavement services.

14 (5) Volunteer services.

15 (6) Inpatient care arrangements.

16 (7) Home health aide services.

17 (e) The services required to be provided pursuant to subdivision
18 (d) shall be provided in compliance with the “Standards for Quality
19 Hospice Care, 2003,” as available from the California Hospice
20 and Palliative Care Association, until the department adopts
21 regulations establishing alternative standards pursuant to
22 subdivision (h).

23 (f) (1) Except as provided in paragraph (2), the applicant shall
24 demonstrate and provide evidence of an unmet need of hospice
25 services in the geographic area that a hospice agency would serve.

26 (2) An applicant for a hospice agency change of ownership need
27 not comply with paragraph (1) for the previously approved service
28 area if the license has been continually held by the previous
29 licensee for five years and one of the following conditions are met:

30 (A) The hospice agency has previously qualified for licensure
31 after demonstrating and providing evidence of unmet need of
32 hospice services in the hospice agency’s geographic area.

33 (B) The hospice agency can demonstrate it is meeting a need
34 for hospice services.

35 (3) If the hospice agency’s approved geographic service area
36 will change upon the change in ownership, the new applicant for
37 licensure shall demonstrate unmet need for hospice services for
38 any new service area.

39 (g) (1) Notwithstanding any law to the contrary, to meet the
40 unique needs of the community, licensed hospice agencies may

1 provide, in addition to hospice services authorized in this chapter,
2 any of the following preliminary services for any person in need
3 of those services, as determined by the physician and surgeon, if
4 any, in charge of the care of a patient, or at the request of the patient
5 or family:

- 6 (A) Preliminary palliative care consultations.
- 7 (B) Preliminary counseling and care planning.
- 8 (C) Preliminary grief and bereavement services.

9 (2) Preliminary services authorized pursuant to this subdivision
10 may be provided concurrently with curative treatment to a person
11 who does not have a terminal prognosis or who has not elected to
12 receive hospice services only by licensed and certified hospices.
13 These services shall be subject to the schedule of benefits under
14 the Medi-Cal program, pursuant to subdivision (w) of Section
15 14132 of the Welfare and Institutions Code.

16 (h) The department may adopt regulations establishing standards
17 for any or all of the services required to be provided under
18 subdivision (d). The regulations of the department adopted pursuant
19 to this subdivision shall supersede the standards referenced in
20 subdivision (e) to the extent the regulations duplicate or replace
21 those standards.

22 *SEC. 15. Section 51312 of the Health and Safety Code is*
23 *amended to read:*

24 51312. (a) The primary purpose of this chapter is to provide
25 an additional method of financing special needs housing.

26 (b) (1) For purposes of this chapter, “special needs housing”
27 means any housing, including supportive housing, intended to
28 benefit, in whole or in part, persons identified as having special
29 needs relating to any of the following:

- 30 (A) Mental health.
- 31 (B) Physical disabilities.
- 32 (C) Developmental disabilities, including, but not limited to,
33 intellectual disability, cerebral palsy, epilepsy, and autism.
- 34 (D) The risk of homelessness.

35 (2) Special needs housing shall also mean housing intended to
36 meet the housing needs of persons eligible for mental health
37 services funded in whole or in part by the ~~Mental Behavioral~~
38 Health Services Fund, created by Section 5890 of the Welfare and
39 Institutions Code.

1 SEC. 16. Section 104751 is added to the Health and Safety
2 Code, to read:

3 104751. (a) The Office of Oral Health, in consultation with
4 the Dental Board of California, the California Dental Association,
5 California dental schools, and other stakeholders, shall support
6 the establishment of community-based clinical education (CBCE)
7 rotations for dental students in their final year or dental residents.

8 (b) To implement this provision, the Office of Oral Health may
9 enter into exclusive or nonexclusive contracts, or amend existing
10 contracts, on a bid or negotiated basis. Contracts entered into or
11 amended pursuant to this subdivision shall be exempt from Chapter
12 6 (commencing with Section 14825) of Part 5.5 of Division 3 of
13 Title 2 of the Government Code and Part 2 (commencing with
14 Section 10100) of Division 2 of the Public Contract Code, and
15 shall be exempt from the review or approval of any division of the
16 Department of General Services.

17 (c) Eligible community clinical settings include, but are not
18 limited to, federally qualified health centers (FQHCs), private
19 dental offices, and mobile dentistry, and shall be located in a
20 designated dental health professional shortage area (DHPSA).

21 (d) The Office of Oral Health shall compile data and prepare
22 a report to be submitted to the Legislature on or before July 1,
23 2027, on all of the following desired outcomes:

24 (1) The number of underserved children and adults served by
25 students and residents.

26 (2) The total number of student and resident trainees.

27 (3) The number of and types of community-based preventative
28 and treatment procedures provided by students.

29 (4) The proportion of graduating dental students and residents
30 rotating in CBCE sites who express interest in working in a
31 DHPSA.

32 (5) The proportion of graduating dental students with CBCE
33 training who will be recruited to FQHCs or other rural and
34 community health clinics through state loan repayment programs,
35 including the Proposition 56 Medi-Cal Physicians and Dentists
36 Loan Repayment Act Program.

37 (e) This section shall remain in effect only until June 30, 2029,
38 and as of that date is repealed.

39 SEC. 17. Section 120956 of the Health and Safety Code is
40 amended to read:

1 120956. (a) The AIDS Drug Assistance Program Rebate Fund
2 is hereby created as a special fund in the State Treasury.

3 (b) All rebates collected from drug manufacturers on drugs
4 purchased through the AIDS Drugs Assistance Program (ADAP)
5 implemented pursuant to this chapter and, notwithstanding Section
6 16305.7 of the Government Code, interest earned on these moneys
7 shall be deposited in the fund exclusively to cover costs related to
8 the purchase of drugs and services provided through ADAP and
9 the HIV prevention programs as described in Sections ~~120972 and~~
10 ~~120972.1, 120972.1, and 120972.2~~ and services related
11 to care and treatment for individuals living with HIV provided
12 through the programs funded by the Transgender, Gender
13 Nonconforming, and Intersex (TGI) Wellness and Equity Fund as
14 described in Section 150900.

15 (c) Notwithstanding Section 13340 of the Government Code,
16 moneys in the fund are continuously appropriated without regard
17 to fiscal year to State Department of Public Health and available
18 for expenditure for those purposes specified under this section.

19 *SEC. 18. Section 120960 of the Health and Safety Code is*
20 *amended to read:*

21 120960. (a) The department shall establish uniform standards
22 of financial eligibility for the drugs under the program established
23 under this chapter.

24 (b) Nothing in the financial eligibility standards shall prohibit
25 drugs to an otherwise eligible person whose modified adjusted
26 gross income does not exceed 500 percent of the federal poverty
27 level per year based on family size and household income.
28 However, the director may authorize drugs for persons with
29 incomes higher than 500 percent of the federal poverty level per
30 year based on family size and household income if the estimated
31 cost of those drugs in one year is expected to exceed 20 percent
32 of the person’s modified adjusted gross income. *Beginning January*
33 *1, 2025, or as soon as technically feasible thereafter, the financial*
34 *eligibility standard in this section shall increase to 600 percent of*
35 *the federal power level per year based on family size and household*
36 *income.*

37 (c) A county public health department administering this
38 program pursuant to an agreement with the director pursuant to
39 subdivision (b) of Section 120955 shall use no more than 5 percent
40 of total payments it collects pursuant to this section to cover any

1 administrative costs related to eligibility determinations, reporting
2 requirements, and the collection of payments.

3 (d) A county public health department administering this
4 program pursuant to subdivision (b) of Section 120955 shall
5 provide all drugs added to the program pursuant to subdivision (a)
6 of Section 120955 within 60 days of the action of the director.

7 (e) For purposes of this section, the following terms shall have
8 the following meanings:

9 (1) “Family size” has the meaning given to that term in Section
10 36B(d)(1) of the Internal Revenue Code of 1986, and shall include
11 same or opposite sex married couples, registered domestic partners,
12 and any tax dependents, as defined by Section 152 of the Internal
13 Revenue Code of 1986, of either spouse or registered domestic
14 partner.

15 (2) “Federal poverty level” refers to the poverty guidelines
16 updated periodically in the Federal Register by the United States
17 Department of Health and Human Services under the authority of
18 Section 9902(2) of Title 42 of the United States Code.

19 (3) “Household income” means the sum of the applicant’s or
20 recipient’s modified adjusted gross income, plus the modified
21 adjusted gross income of the applicant’s or recipient’s spouse or
22 registered domestic partner, and the modified adjusted gross
23 incomes of all other individuals for whom the applicant or
24 recipient, or the applicant’s or recipient’s spouse or registered
25 domestic partner, is allowed a federal income tax deduction for
26 the taxable year.

27 (4) “Internal Revenue Code of 1986” means Title 26 of the
28 United States Code, including all amendments enacted to that code.

29 (5) “Modified adjusted gross income” has the meaning given
30 to that term in Section 36B(d)(2)(B) of the Internal Revenue Code
31 of 1986.

32 *SEC. 19. Section 120972.2 is added to the Health and Safety*
33 *Code, to read:*

34 *120972.2. (a) The State Department of Public Health’s Office*
35 *of AIDS may expend moneys from the AIDS Drug Assistance*
36 *Program Rebate Fund to support prevention services for*
37 *individuals most vulnerable to HIV, including, but not limited to,*
38 *harm reduction services, internal and external condoms, or other*
39 *preventative measures to limit individuals from contracting HIV.*

1 (b) To the extent that funds are available for these purposes,
2 the State Department of Public Health’s Office of AIDS may
3 allocate funds to local health departments and community-based
4 organizations to support HIV prevention.

5 SEC. 20. Section 123322 of the Health and Safety Code is
6 amended to read:

7 123322. (a) In order to effectively manage and administer the
8 federal and state requirements for the vendors in the WIC Program,
9 and remain in compliance with the conditions of federal funding,
10 the department shall establish requirements for all of the following:

11 (1) Retail food delivery systems, as set forth in Section 246.12
12 of Title 7 of the Code of Federal Regulations, including, but not
13 limited to, all of the following:

14 (1)
15 (A) Peer groups and a corresponding reimbursement system.

16 (2)
17 (B) Criteria used for vendor ~~authorization~~, authorization and
18 management.

19 (C) Online shopping.

20 (3)
21 (2) The WIC Program authorized foods.

22 (b) Notwithstanding any other ~~provisions of law~~, including the
23 requirement in Section 123315 for enacting regulations to
24 implement that ~~section and Section 123310~~, the department may,
25 without taking regulatory action pursuant to Chapter 3.5
26 (commencing with Section 11340) of Part 1 of Division 3 of Title
27 2 of the Government Code, implement, interpret, or make specific
28 this section by means of an action by bulletin or similar instruction.
29 section, Section 123310, and Chapter 3.5 (commencing with
30 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
31 Code, the department may implement, interpret, or make specific
32 this section, in whole or in part, by means of all-county letters,
33 plan letters, information notices, provider bulletins, or other
34 similar instructions, without taking any further regulatory action.

35 The department shall provide notice to, and consult with, affected
36 stakeholders, including vendors, manufacturers, local agencies,
37 participants, advocates, consumer groups, and their respective
38 associations, in the process of implementing, interpreting, or
39 making specific this statute, and meet all of the following
40 requirements:

1 (1) The notice shall be provided electronically to the
2 stakeholders identified in this subdivision and shall also be posted
3 on the program's ~~Internet Web site~~. *internet website*. The notice
4 shall state the reason for the change, the authority for the change,
5 and the nature of the change. The notice shall provide opportunity
6 for written comment by indicating the address to which to send
7 the comment. The address may be an electronic site. The notice
8 shall allow for at least 20 calendar days for comments to be
9 submitted. The notice shall also provide the date of a consultation
10 meeting with a stakeholder workgroup consisting of, but not limited
11 to, representatives of stakeholder associations, stakeholder
12 representatives, and consumer groups, to ensure stakeholder
13 participation in the implementation of this section.

14 (2) The department shall consider all comments submitted before
15 the due date, though it may withdraw the proposed action at any
16 time by notification on its ~~Internet Web site~~ *internet website* or
17 notification by electronic means. Unless the department withdraws
18 the action, it shall publish the final action on its ~~Internet Web site~~
19 *internet website* no later than ~~120~~ *180* days after the consultation
20 with stakeholders or the last day for comments, whichever is later.
21 If the department fails to issue a final action within ~~120~~ *180* days
22 from the consultation with stakeholders or the last day for
23 comments, whichever is later, the proposed action will be deemed
24 withdrawn. The department may finalize a proposed action that
25 has been withdrawn by renoticing the proposed action for comment
26 pursuant to paragraphs (1) to (3), inclusive.

27 (3) The department shall provide at least 30 days' advance notice
28 of the final action. In the final action, the department shall respond
29 to the comments received.

30 (4) *WIC authorized vendors approved for online shopping shall*
31 *maintain a fixed physical location in California.*

32 (5) *Notwithstanding Chapter 3.5 (commencing with Section*
33 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
34 *the department may modify or repeal WIC Program requirements*
35 *set forth in Title 22 of the California Code of Regulations pursuant*
36 *to this section by bulletin or similar instruction, without taking*
37 *further regulatory action, if the modification or repeal is filed with*
38 *the Secretary of State and printed in Title 22 of the California*
39 *Code of Regulations.*

40 (4)

1 (6) (A) The department shall establish a process to collect
2 stakeholder feedback regarding the impact of the final action ~~and~~
3 ~~any policy adjustments that should be considered~~
4 ~~postimplementation~~. *taken pursuant to the amendments to this*
5 *section resulting from the Budget Act of 2024 or related trailer*
6 *bill.*

7 (B) *To the extent feasible within existing resources, the*
8 *department shall regularly monitor the impact that online*
9 *purchases made through the WIC Program have on reducing*
10 *barriers to healthy food for people who live in food deserts as well*
11 *as the impact that online WIC purchases have on increasing the*
12 *size of food deserts or the number of food deserts in California.*

13 SEC. 21. *Section 129385 of the Health and Safety Code is*
14 *amended to read:*

15 129385. (a) The Distressed Hospital Loan Program Fund is
16 hereby established in the State Treasury. The fund shall be
17 administered by the department consistent with this chapter.

18 (b) Notwithstanding Section 13340 of the Government Code,
19 all moneys in the fund are continuously appropriated, without
20 regard to fiscal years, for the department and the authority to
21 implement this chapter.

22 (c) The authority shall make secured loans from the Distressed
23 Hospital Loan Program Fund to a hospital or to a governmental
24 entity representing a closed hospital, for purposes of preventing
25 the closure, or facilitating the reopening, of the hospital.

26 (d) The department may allocate an amount not to exceed 5
27 percent of total program funds to administer the program,
28 including, but not limited to, administrative costs to the authority.
29 Any funds transferred shall be available for encumbrance or
30 expenditure until ~~June 30, 2026~~. *December 31, 2031.*

31 (e) (1) The Department of Finance may transfer up to one
32 hundred fifty million dollars (\$150,000,000) from the General
33 Fund to the Distressed Hospital Loan Program Fund between state
34 fiscal years 2022–23 and 2023–24 to implement this chapter.

35 (2) The Department of Finance may transfer, subject to Section
36 14105.200 of the Welfare and Institutions Code, up to one hundred
37 fifty million dollars (\$150,000,000) from the Medi-Cal Provider
38 Payment Reserve Fund to the Distressed Hospital Loan Program
39 Fund in state fiscal year 2023–24 to implement this chapter.

1 (f) All moneys accruing to the authority and the department
2 under this chapter from any source shall be deposited into the fund.

3 (g) The Treasurer may invest moneys in the fund that are not
4 required for its current needs in eligible securities specified in
5 Section 16430 of the Government Code and may transfer moneys
6 in the fund to the Surplus Money Investment Fund for investment
7 pursuant to Article 4 (commencing with Section 16470) of Chapter
8 3 of Part 2 of Division 4 of Title 2 of the Government Code.

9 (h) Notwithstanding Section 16305.7 of the Government Code,
10 all interest or other increment resulting from the investment or
11 deposit of moneys from the fund shall be deposited in the fund.

12 (i) Moneys in the fund shall not be subject to transfer to any
13 other funds pursuant to any provision of Part 2 (commencing with
14 Section 16300) of Division 4 of Title 2 of the Government Code,
15 except to the Surplus Money Investment Fund.

16 (j) Effective December 31, 2031, the Distressed Hospital Loan
17 Program Fund in the State Treasury, created pursuant to this
18 chapter, is hereby abolished. After accounting for all final program
19 transactions, any remaining Distressed Hospital Loan Program
20 Fund reserves shall be returned to the source of origin, in the
21 amounts of up to one hundred fifty million dollars (\$150,000,000)
22 to the General Fund, and up to one hundred fifty million dollars
23 (\$150,000,000) to the Medi-Cal Provider Payment Reserve Fund.
24 Any other remaining balance, assets, liabilities, and encumbrances
25 of the Distressed Hospital Loan Program Fund shall revert to the
26 General Fund. The department shall deposit all subsequent loan
27 repayments or Medi-Cal reimbursements withheld for due cause
28 pursuant to subdivision (b) of Section 129384 to the Treasurer, to
29 the credit of the General Fund.

30 (k) The department and the authority may require any hospital
31 receiving a loan under this chapter to provide the department and
32 the authority with an independent financial audit of the hospital's
33 operations for any fiscal year in which a loan is outstanding.

34 *SEC. 22. Chapter 5 (commencing with Section 131360) is*
35 *added to Part 1 of Division 112 of the Health and Safety Code, to*
36 *read:*

CHAPTER 5. SYNDROMIC SURVEILLANCE SYSTEM

1
2
3
4 131360. For purposes of this chapter, the following terms have
5 the following meanings:

6 (a) “Centers for Disease Control and Prevention” or “CDC”
7 means the national public health agency of the United States. It is
8 a United States federal agency within the Department of Health
9 and Human Services, and is headquartered in Atlanta, Georgia.

10 (b) “Department” means the State Department of Public Health.

11 (c) “Local health department” has the same meaning as defined
12 in Section 101185.

13 (d) “Specified entity” means a general acute care hospital, as
14 defined in Section 1250, with an emergency department, as defined
15 in Section 128700.

16 131365. (a) (1) The department may develop and administer
17 a syndromic surveillance program.

18 (2) The purpose of this chapter is to authorize the department
19 to collect public health and medical data in near real time to detect
20 and investigate changes in the occurrence of disease in the
21 population, especially as a result of a disease outbreak or other
22 public health emergency, disaster, or special event and support
23 to responses to emerging public health threats and conditions
24 impacting the health of California residents.

25 (3) Upon implementation of this chapter, the department shall
26 assign a name to the program.

27 (b) Subject to an appropriation for this purpose, the department
28 may designate an existing syndromic surveillance system or create
29 a new syndromic surveillance system in order to facilitate the
30 reporting of electronic health data by specified entities pursuant
31 to Section 131370.

32 (c) The syndromic surveillance system created or designated
33 by the department pursuant to subdivision (b) shall, at a minimum,
34 provide local health departments access to and use of a secure,
35 integrated electronic health system with standardized analytic
36 tools and processes to rapidly collect, evaluate, share, and store
37 syndromic surveillance data.

38 (d) (1) The list of data elements, electronic transmission
39 standards, data transmission schedule, and instructions pertaining
40 to the program may be modified at any time by the department.

1 (2) *The department shall collaborate with local health*
2 *departments to determine modifications to be made pursuant to*
3 *this subdivision.*

4 (3) *Modifications made pursuant to this subdivision shall be*
5 *exempt from the administrative regulation and rulemaking*
6 *requirements of Chapter 3.5 (commencing with Section 11340) of*
7 *Part 1 of Division 3 of Title 2 of the Government Code and shall*
8 *be implemented without being adopted as a regulation, except that*
9 *the revisions shall be filed with the Secretary of State and printed*
10 *and published in Title 17 of the California Code of Regulations.*

11 131370. (a) (1) (A) *A specified entity shall submit the required*
12 *data electronically to the syndromic surveillance system developed*
13 *by the department in accordance with the schedule, standards,*
14 *and requirements established by the department.*

15 (B) *Notwithstanding subparagraph (A), a specified entity shall*
16 *submit the required data electronically to a local health department*
17 *that participates in a syndromic surveillance system or maintains*
18 *its own system pursuant to subdivision (b).*

19 (C) *The department may adopt regulations, in accordance with*
20 *the Administrative Procedure Act (Chapter 3.5 (commencing with*
21 *Section 11340) of Part 1 of Division 3 of the Government Code),*
22 *to specify any other entity that is required to provide data pursuant*
23 *to this section.*

24 (2) *A specified entity shall collect and report data to the*
25 *department or local syndromic surveillance system, if applicable,*
26 *as near as possible to real time.*

27 (b) (1) (A) *A specified entity may decline to report electronic*
28 *health data to the department if the local health department in*
29 *which the specified entity is located participates in a syndromic*
30 *surveillance system or maintains its own system that has, or by no*
31 *later than July 1, 2027, will have, the capacity to transmit the*
32 *specified entity's required electronic health and medical data to*
33 *the department's designated syndromic surveillance system in near*
34 *real time and the specified entity reports electronic health and*
35 *medical data to the local health department's syndromic*
36 *surveillance system.*

37 (B) *The department shall provide guidance and technical*
38 *assistance to local health departments that participate in a*
39 *syndromic surveillance system or maintains its own system to*

1 *develop automated transmission of data from local syndromic*
2 *surveillance systems into the state system by July 1, 2027.*

3 *(2) Notwithstanding paragraph (1), a specified entity is not*
4 *required to report data to the department only if the local health*
5 *department reports the entity's required data to the department's*
6 *designated syndromic surveillance system pursuant to this section*
7 *by July 1, 2027.*

8 *(3) This subdivision does not limit the ability of a local health*
9 *department to require a specified entity to submit additional data*
10 *to the local health department in addition to the data required to*
11 *be submitted to the department.*

12 *(c) The data elements, electronic transmission standards, data*
13 *transmission schedule, and instructions for the data collection*
14 *required pursuant to this section include, but are not limited to,*
15 *any element or requirement adopted for use by the CDC's Public*
16 *Health Information Network (PHIN) Messaging Guide for*
17 *Syndromic Surveillance: Emergency Department, Urgent Care,*
18 *Inpatient and Ambulatory Care Settings, Release 2.0 (April 2015),*
19 *or any subsequent versions.*

20 *(d) No civil or criminal penalty, fine, sanction, or finding, or*
21 *denial, suspension, or revocation of licensure for any person or*
22 *facility may be imposed based upon a failure to provide the data*
23 *elements required pursuant to this chapter, unless the data*
24 *elements, electronic transmission standards, and data transmission*
25 *schedule submissions required to be provided by the specified*
26 *entity was printed in the California Code of Regulations and the*
27 *department notified the person or facility of the data reporting*
28 *requirement at least six months prior to the date of the claimed*
29 *failure to report or submit the data.*

30 *131375. (a) To support local public health activities, the*
31 *department shall provide each local health department as near as*
32 *possible to real-time access to its jurisdiction's data entered into*
33 *the state syndromic surveillance system.*

34 *(b) The department, at its discretion, may approve the sharing*
35 *of data collected pursuant to Section 131370 with all of the*
36 *following entities:*

37 *(1) State governmental entities.*

38 *(2) Local health departments.*

1 (3) Specified entities as defined in Section 131360 authorized
2 by the department, if access is limited to the specified entity's own
3 data.

4 (c) The department, at its discretion, may approve the sharing
5 of data collected pursuant to Section 131370 with persons with a
6 valid scientific interest who are engaged in demographic,
7 epidemiological, or other similar studies related to health. Persons
8 with a valid scientific interest who are engaged in demographic,
9 epidemiological, or other similar studies related to health that are
10 interested in receiving data collected pursuant to Section 131370
11 shall submit a request to and obtain the approval of the Committee
12 for the Protection of Human Subjects.

13 (d) Notwithstanding Section 1798.24 of the Information
14 Practices Act of 1977 (Chapter 1 (commencing with Section 1798)
15 of Title 1.8 of Part 4 of Division 3 of the Civil Code), the
16 department, at its discretion, may approve the sharing of data
17 collected pursuant to Section 131370 with the CDC, if the CDC
18 agrees in writing to maintain the confidentiality of the data before
19 confidential data is disclosed.

20 131380. (a) All data collected pursuant to this chapter shall
21 be confidential.

22 (b) For any disclosure authorized by Section 131375, the
23 disclosing entity shall only include data relevant and necessary
24 for the approved purpose of the requested disclosure.

25 (c) An entity authorized pursuant to subdivisions (a) and (b) of
26 Section 131375 that receives confidential data from the department
27 shall do all of the following:

28 (1) Agree in writing to maintain the confidentiality of the data
29 before confidential data is disclosed.

30 (2) Ensure that a patient's rights to confidentiality shall not be
31 violated in any manner.

32 (3) Not disclose the data to any other entity.

33 (4) Safeguard the confidential data from unauthorized
34 disclosure.

35 (5) Only use the disclosed data for an approved purpose.

36 (d) An entity authorized pursuant to subdivision (c) of Section
37 131375 that receives confidential data from the department shall
38 comply with the requirements set forth by the Center for Data
39 Insights and Innovation in Sections 130206, 103206.1, and
40 103206.2.

1 (e) *The furnishing of confidential data to an entity in accordance*
2 *with this section will not expose any person, agency, or entity*
3 *furnishing data to liability, and shall not be considered a waiver*
4 *of any privilege or a violation of a confidential relationship.*

5 (f) (1) *The department shall maintain an accurate record of all*
6 *persons who are given access to confidential data. The record*
7 *shall include all of the following:*

8 (A) *The name of the person authorizing access.*

9 (B) *The name, title, address, and organizational affiliation of*
10 *the person given access.*

11 (C) *The dates of access.*

12 (D) *The specific purpose for which the data is to be used.*

13 (2) *The record of access shall be open to public inspection*
14 *during normal operating hours of the department.*

15 (g) *The confidential data shall be exempt from disclosure under*
16 *the California Public Records Act (Division 10 (commencing with*
17 *Section 7920.000) of Title 1 of the Government Code) and from*
18 *subpoena. The confidential data shall not be disclosed,*
19 *discoverable, or compelled to be produced in any civil, criminal,*
20 *administrative, or other proceeding, and shall not be deemed*
21 *admissible as evidence in any civil, criminal, administrative, or*
22 *other tribunal or court for any reason.*

23 (h) *This section does not prohibit the publication by the*
24 *department of reports and statistical compilations that do not in*
25 *any way identify individual cases or individual sources of*
26 *information.*

27 *SEC. 23. Section 10113.9 of the Insurance Code is amended*
28 *to read:*

29 10113.9. (a) *This section shall not apply to vision-only,*
30 *dental-only, or CHAMPUS supplement insurance, or to hospital*
31 *indemnity, hospital-only, accident-only, or specified disease*
32 *insurance that does not pay benefits on a fixed benefit, cash*
33 *payment only basis.*

34 (b) (1) *A change in the premium rate or coverage for an*
35 *individual health insurance policy shall not become effective unless*
36 *the insurer has provided a written notice of the change at least 10*
37 *days before the start of the annual enrollment period applicable to*
38 *the policy or 60 days before the effective date of the policy renewal,*
39 *whichever occurs earlier in the calendar year.*

1 (2) The written notice required pursuant to paragraph (1) shall
2 be provided to the individual policyholder at ~~his or her~~ *their* last
3 address known to the insurer. The notice shall state in italics and
4 in 12-point type the actual dollar amount of the premium increase
5 and the specific percentage by which the current premium will be
6 increased. The notice shall describe in plain, understandable
7 English any changes in the policy or any changes in benefits,
8 including a reduction in benefits or changes to waivers, exclusions,
9 or conditions, and highlight this information by printing it in italics.
10 The notice shall specify in a minimum of 10-point bold typeface,
11 the reason for a premium rate change or a change in coverage or
12 benefits.

13 (c) (1) If the department determines that a rate is unreasonable
14 or not justified consistent with Article 4.5 (commencing with
15 Section 10181), the insurer shall notify the policyholder of this
16 determination. This notification may be included in the notice
17 required in subdivision (b). The notification to the policyholder
18 shall be developed by the department. The development of the
19 notification required under this subdivision shall not be subject to
20 the Administrative Procedure Act (Chapter 3.5 (commencing with
21 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
22 Code).

23 (2) The notification to the policyholder shall include the
24 following statements in 14-point type:

25 (A) The Department of Insurance has determined that the rate
26 for this product is unreasonable or not justified after reviewing
27 information submitted to it by the insurer.

28 (B) During the open enrollment period, the policyholder has
29 the option to obtain other coverage from this insurer or another
30 insurer, or to keep this coverage.

31 (C) The policyholder may want to contact Covered California
32 at www.coveredca.com for help in understanding available options.

33 (D) Many Californians are eligible for financial assistance from
34 Covered California to help pay for coverage.

35 (3) The insurer may include in the notification to the
36 policyholder the ~~Internet Web site~~ *internet website* address at which
37 the insurer's final justification for implementing an increase that
38 has been determined to be unreasonable by the commissioner may
39 be found pursuant to Section 154.230 of Title 45 of the Code of
40 Federal Regulations.

1 (4) The notice shall also be provided to the agent of record for
2 the policyholder, if any, so that the agent may assist the purchaser
3 in finding other coverage.

4 (5) In developing the notification, the department shall take into
5 consideration that this notice is required to be provided to an
6 individual applicant pursuant to subdivision (g) of Section 10181.3.

7 (d) ~~¶(1) Before July 1, 2024, if~~ an insurer rejects a dependent
8 of a policyholder applying to be added to the policyholder's
9 individual grandfathered health plan, rejects an applicant for a
10 Medicare supplement policy due to the applicant having end-stage
11 renal disease, or offers an individual grandfathered health plan to
12 an applicant at a rate that is higher than the standard rate, the
13 insurer shall inform the applicant about the California Major Risk
14 Medical Insurance Program (MRMIP) (Chapter 4 (commencing
15 with Section 15870) of Part 3.3 of Division 9 of the Welfare and
16 Institutions Code) and about the new coverage options and the
17 potential for subsidized coverage through Covered California. The
18 insurer shall direct persons seeking more information to MRMIP,
19 Covered California, plan or policy representatives, insurance
20 agents, or an entity paid by Covered California to assist with health
21 coverage enrollment, such as a navigator or an assister.

22 (2) *On or after July 1, 2024, if an insurer rejects a dependent*
23 *of a policyholder applying to be added to the policyholder's*
24 *individual grandfathered health plan, rejects an applicant for a*
25 *Medicare supplement policy due to the applicant having end-stage*
26 *renal disease, or offers an individual grandfathered health plan*
27 *to an applicant at a rate that is higher than the standard rate, the*
28 *insurer shall inform the applicant about new coverage options*
29 *and the potential for subsidized coverage through Covered*
30 *California. The insurer shall direct persons seeking more*
31 *information to Covered California, plan or policy representatives,*
32 *insurance agents, or an entity paid by Covered California to assist*
33 *with health coverage enrollment, such as a navigator or an assister.*

34 (e) A notice provided pursuant to this section is a private and
35 confidential communication and, at the time of application, the
36 insurer shall give the applicant the opportunity to designate the
37 address for receipt of the written notice in order to protect the
38 confidentiality of personal or privileged information.

39 (f) For purposes of this section, the following definitions shall
40 apply:

1 (1) “Covered California” means the California Health Benefit
2 Exchange established pursuant to Section 100500 of the
3 Government Code.

4 (2) “Grandfathered health plan” has the same meaning as that
5 term is defined in Section 1251 of PPACA.

6 (3) “PPACA” means the federal Patient Protection and
7 Affordable Care Act (Public Law 111-148), as amended by the
8 federal Health Care and Education Reconciliation Act of 2010
9 (Public Law 111-152), and rules, regulations, or guidance issued
10 pursuant to that law.

11 *SEC. 24. Section 12693.74 of the Insurance Code, as amended*
12 *by Section 35 of Chapter 47 of the Statutes of 2022, is amended*
13 *to read:*

14 12693.74. (a) Subscribers shall continue to be eligible for the
15 program for a period of 12 months from the month eligibility is
16 established.

17 (b) (1) *If the voters approve the addition of Chapter 7.5*
18 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
19 *the Welfare and Institutions Code at the November 5, 2024,*
20 *statewide general election and the conditions described in*
21 *paragraph (1) of subdivision (b) of Section 12693.74, as added by*
22 *Section 36 of the act that added this subdivision, have been met,*
23 *this section shall become inoperative on January 1, 2025, or the*
24 *date certified by the State Department of Health Care Services*
25 *pursuant to paragraph (2) of subdivision (b) of Section 12693.74,*
26 *as added by Section 36 of the act that added this subdivision,*
27 *whichever is later, and shall be repealed on January 1 directly*
28 *following that date.*

29 (2) *If the voters do not approve the addition of Chapter 7.5*
30 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
31 *the Welfare and Institutions Code at the November 5, 2024,*
32 *statewide general election and the conditions described in*
33 *paragraph (1) of subdivision (b) of Section 15832, as added by*
34 *Section 137 of the act that added this subdivision, have been met,*
35 *this section shall become inoperative on January 1, 2026, or the*
36 *date certified by the department pursuant to paragraph (2) of*
37 *subdivision (b) of Section 15832, as added by Section 137 of the*
38 *act that added this subdivision, whichever is later, and shall be*
39 *repealed on January 1 directly following that date.*

1 *SEC. 25. Section 12693.74 of the Insurance Code, as added*
2 *by Section 36 of Chapter 47 of the Statutes of 2022, is amended*
3 *to read:*

4 12693.74. (a) To the extent federal financial participation is
5 available, and subject to subdivision (e), the child shall remain
6 continuously eligible for the program up to five years of age. The
7 department shall seek any federal approvals that may be necessary
8 to implement this subdivision.

9 (b) (1) Implementation of this section is contingent on all of
10 the following conditions:

11 (A) All necessary federal approvals have been obtained by the
12 department pursuant to subdivision (e).

13 (B) The Legislature has appropriated funding to implement this
14 section after a determination that ongoing General Fund resources
15 are available to support the ongoing implementation of this section
16 in the 2024–25 fiscal year and subsequent fiscal years.

17 (C) The department has determined that systems have been
18 programmed to implement this section.

19 (2) The department shall issue a declaration certifying the date
20 that all conditions in paragraph (1) have been met. The department
21 shall post the declaration on its internet website and provide a copy
22 of the declaration to the Secretary of State, the Secretary of the
23 Senate, the Chief Clerk of the Assembly, and the Legislative
24 Counsel.

25 (c) If at any time the director determines that the eligibility
26 criteria established under this section for the program may
27 jeopardize the state's ability to receive federal financial
28 participation under the federal Patient Protection and Affordable
29 Care Act (Public Law 111-148), any amendment or extension of
30 that act, or any similar federal legislation affecting federal financial
31 participation, the director may alter the eligibility criteria to the
32 extent necessary for the state to receive that federal financial
33 participation.

34 (d) Notwithstanding Chapter 3.5 (commencing with Section
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
36 and Chapter 4 (commencing with Section 12693.25) and Part 6.1
37 (commencing with Section 12670), the department may implement,
38 interpret, or make specific this section, in whole or in part, through
39 all-county letters or similar instructions, without taking any further
40 regulatory action.

1 (e) This section shall be implemented only to the extent that
2 any necessary federal approvals are obtained, and federal financial
3 participation is available and not otherwise jeopardized.

4 (f) ~~This~~ (1) *If the voters approve the addition of Chapter 7.5*
5 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
6 *the Welfare and Institutions Code at the November 5, 2024,*
7 *statewide general election, this section shall become operative on*
8 *January 1, 2025, or the date certified by the department pursuant*
9 *to paragraph (2) of subdivision (b), whichever is later.*

10 (2) *If the voters do not approve the addition of Chapter 7.5*
11 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
12 *the Welfare and Institutions Code at the November 5, 2024,*
13 *statewide general election, this section shall be repealed as of*
14 *January 1, 2025.*

15 *SEC. 26. Section 12693.74 is added to the Insurance Code, to*
16 *read:*

17 *12693.74. (a) To the extent federal financial participation is*
18 *available, and subject to subdivision (e), the child shall remain*
19 *continuously eligible for the program up to five years of age. The*
20 *department shall seek any federal approvals that may be necessary*
21 *to implement this subdivision.*

22 (b) (1) *Implementation of this section is contingent on both of*
23 *the following conditions:*

24 (A) *All necessary federal approvals have been obtained by the*
25 *department pursuant to subdivision (e).*

26 (B) *The department has determined that systems have been*
27 *programmed to implement this section.*

28 (2) *The department shall issue a declaration certifying the date*
29 *that all conditions in paragraph (1) have been met. The department*
30 *shall post the declaration on its internet website and provide a*
31 *copy of the declaration to the Secretary of State, the Secretary of*
32 *the Senate, the Chief Clerk of the Assembly, and the Legislative*
33 *Counsel.*

34 (c) *If at any time the director determines that the eligibility*
35 *criteria established under this section for the program may*
36 *jeopardize the state's ability to receive federal financial*
37 *participation under the federal Patient Protection and Affordable*
38 *Care Act (Public Law 111-148), any amendment or extension of*
39 *that act, or any similar federal legislation affecting federal*
40 *financial participation, the director may alter the eligibility criteria*

1 *to the extent necessary for the state to receive that federal financial*
2 *participation.*

3 *(d) Notwithstanding Chapter 3.5 (commencing with Section*
4 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
5 *and Part 6.1 (commencing with Section 12670) and Chapter 4*
6 *(commencing with Section 12693.25) of Part 6.2, the department*
7 *may implement, interpret, or make specific this section, in whole*
8 *or in part, through all-county letters or similar instructions, without*
9 *taking any further regulatory action.*

10 *(e) This section shall be implemented only to the extent that any*
11 *necessary federal approvals are obtained, and federal financial*
12 *participation is available and not otherwise jeopardized.*

13 *(f) (1) If the voters do not approve the addition of Chapter 7.5*
14 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
15 *the Welfare and Institutions Code at the November 5, 2024,*
16 *statewide general election, this section shall become operative on*
17 *January 1, 2026, or the date certified by the department pursuant*
18 *to paragraph (2) of subdivision (b), whichever is later.*

19 *(2) If the voters approve the addition of Chapter 7.5*
20 *(commencing with Section 14199.100) to Part 3 of Division 9 of*
21 *the Welfare and Institutions Code at the November 5, 2024,*
22 *statewide general election, this section shall be repealed as of*
23 *January 1, 2025.*

24 *SEC. 27. Section 1182.14 of the Labor Code is amended to*
25 *read:*

26 1182.14. (a) The Legislature finds and declares as follows:

27 (1) Workers in the health care industry, including workers at
28 general acute care hospitals, acute psychiatric hospitals, medical
29 offices and clinics, behavioral health centers, and residential care
30 centers provide vital health care services to California residents,
31 including emergency care, labor and delivery, cancer treatments,
32 and primary and specialty care. Similarly, dialysis clinics provide
33 life-preserving care to patients with end-stage renal disease and
34 are part of the continuum of kidney care that also includes hospitals
35 and health systems. Residents and visitors to the state rely on access
36 to this high-quality health care.

37 (2) Higher wages are an important means of retaining an
38 experienced workforce and attracting new workers. A stable
39 workforce benefits patients and improves quality of care.

1 (3) Employers across multiple industries are raising wages. The
2 health care sector in California must offer higher wages to remain
3 competitive.

4 (4) Members of the health care team such as certified nursing
5 assistants, patient aides, technicians, and food service workers,
6 among many others, are essential to both routine medical care and
7 emergency response efforts.

8 (5) Even before the COVID-19 pandemic, California was facing
9 an urgent and immediate shortage of health care workers, adversely
10 impacting the health and well-being of Californians, especially
11 economically disadvantaged Californians. The pandemic has
12 worsened these shortages. Higher wages are needed to attract and
13 retain health care workers to treat patients, including being prepared
14 to provide necessary care in an emergency.

15 (6) The Legislature finds and declares that laws that establish,
16 require, impose, limit or otherwise relate to wages, salary, or
17 compensation affect access to quality health care for all residents
18 of, and visitors to, the state provided by licensed health care
19 facilities, which serve as a critical part of the state's ability to
20 respond to catastrophic emergencies. The Legislature also finds
21 and declares that the time limitations and other provisions
22 established by this section are necessary to stabilize the health care
23 system following the state and federal public health emergencies
24 related to COVID-19, the closure and bankruptcy of licensed health
25 care facilities, and the reduction in vital services by licensed health
26 care facilities due to financial distress and the health care workforce
27 crisis that has resulted in staffing shortages and strain for health
28 care workers. The Legislature further finds and declares that access
29 to quality health care and the stability of the health care system is
30 a matter of statewide concern and is not a municipal affair as that
31 term is used in Section 5 of Article XI of the California
32 Constitution. Therefore, this section occupies the whole field of
33 wages, salary, or compensation for covered health care facility
34 employees, and applies to all cities and counties, including charter
35 cities, charter counties, and charter cities and counties during the
36 stabilization period provided by this section.

37 (7) *The Legislature finds and declares that it is the intent of the*
38 *Legislature that subclause (I) of clause (ii) of subparagraph (B)*
39 *of paragraph (2) of subdivision (b) is declarative of existing law.*

40 (b) As used in this section:

1 (1) “Adjusted patient days” means the total gross patient
2 revenue, divided by gross revenue provided for inpatient services,
3 multiplied by the number of patient days.

4 (2) (A) “Covered health care employee” means any of the
5 following:

6 (i) An employee of a health care facility employer who provides
7 patient care, health care services, or services supporting the
8 provision of health care, which includes, but is not limited to,
9 employees performing work in the occupation of a nurse, physician,
10 caregiver, medical resident, intern or fellow, patient care technician,
11 janitor, housekeeping staff person, groundskeeper, guard, clerical
12 worker, nonmanagerial administrative worker, food service worker,
13 gift shop worker, technical and ancillary services worker, medical
14 coding and medical billing personnel, scheduler, call center and
15 warehouse worker, and laundry worker, regardless of formal job
16 title.

17 (ii) A contracted or subcontracted employee described in
18 subparagraph (B).

19 (B) “Covered health care employee” includes a contracted or
20 subcontracted employee, if ~~all of the following apply:~~ *clauses (i)*
21 *and (ii) apply:*

22 (i) The employee’s employer contracts with the *covered* health
23 care facility employer, or with a contractor or subcontractor to the
24 *covered* health care facility employer, to provide health care
25 services, or services supporting the provision of health care.

26 (ii) ~~The (I) Consistent with the definitions of “employ” and~~
27 ~~“employer” in the Industrial Welfare Commission wage orders,~~
28 *the covered* health care facility employer directly or indirectly, or
29 through an agent or any other person, *engages, suffers, or permits*
30 *an employee to work, or exercises control over the employee’s*
31 *wages, hours or working conditions. However, “covered health*
32 *care employee” includes all employees performing conditions, or*

33 (II) *The employee performs* contracted or subcontracted work
34 primarily on the premises of a *covered* health care ~~facility to~~
35 ~~provide facility.~~ *For purposes of this subparagraph, “primarily”*
36 *means more than one-half of the employee’s work time during a*
37 *workweek.*

38 (iii) *A contracted or subcontracted employee shall be paid the*
39 *applicable minimum wage in this section for all hours worked*

1 *providing patient care, health care services services, or services*
2 *supporting the provision of health care.*

3 (C) Notwithstanding subparagraph (A), “covered health care
4 employee” does not include:

5 (i) Employment as an outside salesperson.

6 (ii) Any work performed ~~in the public sector where the primary~~
7 ~~duties performed are not health care services.~~ *by a public employee*
8 *where the public employee is not primarily engaged in services*
9 *described in clause (i) of subparagraph (A) performed for a*
10 *covered health care facility. For purposes of this subparagraph,*
11 *“primarily” means more than one-half of the employee’s work*
12 *time during a workweek.*

13 (iii) Delivery or waste collection work on the premises of a
14 covered health care facility, provided that the delivery or waste
15 collection worker is not an employee of any person that owns,
16 controls, or operates a covered health care facility.

17 (iv) Medical transportation services in or out of a covered health
18 care facility, provided that the medical transportation services
19 worker is not an employee of any person that owns, controls, or
20 operates a covered health care facility.

21 (3) (A) “Covered health care facility” means any of the
22 following:

23 (i) A facility or other work site that is part of an integrated health
24 care delivery system.

25 (ii) A licensed general acute care hospital, as defined in
26 subdivision (a) of Section 1250 of the Health and Safety Code,
27 including a distinct part of any such hospital.

28 (iii) A licensed acute psychiatric hospital, as defined in
29 subdivision (b) of Section 1250 of the Health and Safety Code,
30 including a distinct part of any such hospital.

31 (iv) A special hospital, as defined in subdivision (f) of Section
32 1250 of the Health and Safety Code.

33 (v) A licensed skilled nursing facility, as defined in subdivision
34 (c) of Section 1250 of the Health and Safety Code, if owned,
35 operated, or controlled by a hospital or integrated health care
36 delivery system or health care system.

37 (vi) A patient’s home when health care services are delivered
38 by an entity owned or operated by a general acute care hospital or
39 acute psychiatric hospital.

- 1 (vii) A licensed home health agency, as defined in subdivision
2 (a) of Section 1727 of the Health and Safety Code.
- 3 (viii) A clinic, as defined in subdivision (b) of Section 1204 of
4 the Health and Safety Code, including a specialty care clinic, or a
5 dialysis clinic.
- 6 (ix) A psychology clinic, as defined in Section 1204.1 of the
7 Health and Safety Code.
- 8 (x) A clinic as defined in subdivision (d), (g), or (l) of Section
9 1206 of the Health and Safety Code.
- 10 (xi) A licensed residential care facility for the elderly, as defined
11 in Section 1569.2 of the Health and Safety Code, if affiliated with
12 an acute care provider or owned, operated, or controlled by a
13 general acute care hospital, acute psychiatric hospital, or the parent
14 entity of a general acute care hospital or acute psychiatric hospital.
- 15 (xii) A psychiatric health facility, as defined in Section 1250.2
16 of the Health and Safety Code.
- 17 (xiii) A mental health rehabilitation center, as defined in Section
18 5675 of the Welfare and Institutions Code.
- 19 (xiv) A community clinic licensed under subdivision (a) of
20 Section 1204 of the Health and Safety Code, an intermittent clinic
21 exempt from licensure under subdivision (h) of Section 1206 of
22 the Health and Safety Code, or a clinic operated by ~~the state or~~
23 ~~any of its political subdivisions, including, but not limited to, any~~
24 *political subdivisions of the state, including* the University of
25 California or a city or county that is exempt from licensure under
26 subdivision (b) of Section 1206 of the Health and Safety Code.
- 27 (xv) A rural health clinic, as defined in paragraph (1) of
28 subdivision (l) of Section 1396d of Title 42 of the United States
29 ~~Code. Code, that is not license exempt.~~
- 30 (xvi) An urgent care clinic.
- 31 (xvii) An ambulatory surgical center that is certified to
32 participate in the Medicare Program under Title XVIII (42 U.S.C.
33 Sec. 1395 et seq.) of the federal Social Security Act.
- 34 (xviii) A physician group.
- 35 (xix) A county correctional facility that provides health care
36 services.
- 37 (xx) A county mental health facility.
- 38 (B) “Covered health care facility” does not include either of the
39 following:

1 ~~(i) A hospital owned, controlled, or operated by the State~~
2 ~~Department of State Hospitals.~~

3 *(i) Any health care facility described in subparagraph (A) that*
4 *is owned, controlled, or operated by the state or any state agency*
5 *of the executive branch. As used in this subparagraph, “state*
6 *agency” includes every state office, officer, department, division,*
7 *bureau, board, and commission under the executive branch,*
8 *including any constitutional offices or officers, California State*
9 *University, or California Community College, but does not include*
10 *a health care district or the University of California.*

11 *(ii) A tribal clinic exempt from licensure under subdivision (c)*
12 *of Section 1206 of the Health and Safety Code, or an outpatient*
13 *setting conducted, maintained, or operated by a federally*
14 *recognized Indian tribe, tribal organization, or urban Indian*
15 *organization, as defined in Section 1603 of Title 25 of the United*
16 *States Code.*

17 (4) “Employ” means to engage, suffer, or permit to work.

18 (5) “Employee” means any person employed by an employer.

19 (6) “Employer” means a person who directly or indirectly, or
20 through an agent or any other person, employs or exercises control
21 over the wages, hours, or working conditions of any person.
22 “Employer” includes ~~the state,~~ political subdivisions of the state,
23 *health care districts,* the University of California, and
24 municipalities.

25 (7) “Full-time equivalent employee” means the total paid hours
26 at a covered health care facility, including an integrated health
27 care delivery system, as of January 1, 2022, ~~as per Department of~~
28 ~~Health Care Access and Information guidance,~~ divided by 2,080.
29 *The number of full-time equivalent employees shall be determined*
30 *as follows:*

31 *(A) The number of full-time equivalent employees shall be as*
32 *detailed in the Department of Health Care Access and*
33 *Information’s 2021 Pivot Table – Hospital Annual Selected File*
34 *(April 2023 Extract) and published online at*
35 *<https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables>.*
36 *For purposes of determining the number of full-time equivalent*
37 *employees under this subparagraph, published data in the pivot*
38 *table shall be aggregated to determine the total full-time equivalent*
39 *employees for an integrated health care delivery system or health*
40 *system. As provided by paragraph (1) of subdivision (c), any*

1 covered health care facility employer that is part of these systems
2 shall be subject to the minimum wage schedule described in
3 paragraph (1) of subdivision (c).

4 (B) Any covered health care facility employer that does not
5 report the data referenced in subparagraph (A), but had 10,000
6 or more full-time equivalent employees as of January 1, 2022,
7 shall be subject to the minimum wage schedule described in
8 paragraph (1) of subdivision (c). For the purposes of this
9 paragraph, “full-time equivalent employees” means the total
10 number of paid hours at a nonreporting covered health care facility
11 employer divided by 2,080. This subparagraph does not apply to
12 county entities, except as counties that are specifically covered in
13 subdivision (c).

14 (8) “Health care services” means patient care-related services
15 including nursing; caregiving; services provided by medical
16 residents, interns, or fellows; technical and ancillary services;
17 janitorial work; housekeeping; groundskeeping; guard duties;
18 business office clerical work; food services; laundry; medical
19 coding and billing; call center and warehouse work; scheduling;
20 and gift shop work; but only where such services support patient
21 care.

22 (9) “Health care worker minimum wage” means the minimum
23 wage rate established by this section.

24 (10) “Health care system” means a parent entity that owns,
25 controls, or operates two or more separately licensed hospitals.

26 (11) “Hospital with a high governmental payor mix” means a
27 licensed acute care hospital, as defined in subdivision (a) or (b) of
28 Section 1250 of the Health and Safety Code, where the combined
29 Medicare and Medi-Cal payor mix is 90 percent or greater, as
30 determined by using the adjusted patient days from the Department
31 of Health Care Access and Information annual financial disclosure
32 report, as recorded and calculated as of January 1, 2022, as per the
33 Department of Health Care Access and Information guidance. A
34 hospital shall qualify pursuant to this paragraph only if the
35 combined payor mix of both the hospital and the health care system
36 to which it belongs, if any, is 90 percent or greater.

37 (12) “Independent hospital with an elevated governmental payor
38 mix” means all of the following:

39 (A) A hospital, as defined in subdivision (a) or (b) of Section
40 1250 of the Health and Safety Code, where the combined Medicare

1 and Medi-Cal payor mix is 75 percent or greater, as determined
2 by using the adjusted patient days from the Department of Health
3 Care Access and Information annual financial disclosure report,
4 as recorded and calculated as of January 1, 2022, as per the
5 Department of Health Care Access and Information guidance.

6 (B) The hospital is not owned, controlled, or operated by any
7 parent entity with two or more separately licensed hospitals.

8 (13) “Integrated health care delivery system” means an entity
9 or group of related entities that includes both of the following: (A)
10 one or more hospitals and (B) one or more physician groups, health
11 care service plans, medical foundation clinics, other health care
12 facilities, or other entities, providing health care or supporting the
13 provision of health care, where the hospital or hospitals and other
14 entities are related through one of the following:

15 (A) Parent and subsidiary relationships, joint or common
16 ownership or control, common branding, or common boards of
17 directors and shared senior management.

18 (B) A contractual relationship in which affiliated covered
19 physician groups or medical foundation clinics contract with a
20 health care service plan, hospital or other part of the system, all
21 operating under a common trade name.

22 (C) A contractual relationship in which a nonprofit health care
23 service plan provides medical services to enrollees in a specific
24 geographic region of the state through an affiliated hospital system,
25 and contracts with a single covered physician group in each
26 geographic region of the state to provide medical services to a
27 majority of the plan’s enrollees in that region.

28 (14) “Physician group” means a medical group practice,
29 including a professional medical corporation, as defined in Section
30 2406 of the Business and Professions Code, another form of
31 corporation controlled by physicians and surgeons, or a medical
32 partnership, provided that the group includes a total of 25 or more
33 physicians.

34 (15) “Rural independent covered health care facility” means a
35 hospital that is not part of an integrated health care delivery system
36 and is not owned, controlled, or operated by any parent entity with
37 two or more separately licensed hospitals and any of the following:

38 (A) A hospital that is located in a county that is not designated
39 as a metropolitan core-based statistical ~~area~~: *area as of March*
40 *2020*.

1 (B) A small and rural hospital, as defined in Section 124840 of
2 the Health and Safety Code.

3 (C) A rural general acute care hospital, as described in Section
4 1250 of the Health and Safety Code.

5 (16) “Urgent care clinic” means a facility or clinic that provides
6 immediate, nonemergent ambulatory medical care to patients,
7 including, but not limited to, facilities known as walk-in clinics
8 or centers or urgent care centers.

9 (c) (1) For any covered health care facility employer with
10 10,000 or more full-time equivalent employees, any covered health
11 care facility employer that is a part of an integrated health care
12 delivery system or health care system with 10,000 or more full-time
13 equivalent employees, any covered health care facility employer
14 that is a dialysis clinic as defined in subdivision (b) of Section
15 1204 of the Health and Safety Code or that is a person that owns,
16 controls, or operates a dialysis clinic, or a covered health facility
17 owned, affiliated, or operated by a county with a population of
18 more than 5,000,000 as of January 1, 2023, the minimum wage
19 for all covered health care employees shall be as follows:

20 (A) From July 1, 2024, to June 30, 2025, inclusive, twenty-three
21 dollars (\$23) per hour.

22 (B) From July 1, 2025, to June 30, 2026, inclusive, twenty-four
23 dollars (\$24) per hour.

24 (C) From July 1, 2026, and until adjusted pursuant to
25 subdivision (d), twenty-five dollars (\$25) per hour.

26 (2) For any hospital that is a hospital with a high governmental
27 payor mix, an independent hospital with an elevated governmental
28 payor mix, a rural independent covered health care facility, or a
29 covered health care facility that is owned, affiliated, or operated
30 by a county with a population of less than 250,000 as of January
31 1, 2023, the minimum wage for all covered health care employees
32 shall be as follows:

33 (A) From July 1, 2024, to June 30, 2033, inclusive, eighteen
34 dollars (\$18) per hour, with 3.5 percent increases annually.

35 (B) From July 1, 2033, and until adjusted pursuant to subdivision
36 (d), twenty-five (\$25) per hour.

37 (3) (A) For any health care facility specified in clauses (i) to
38 (iv), inclusive, the minimum wage for all covered health care
39 employees shall be as set forth in subparagraph (B).

- 1 (i) A clinic as defined in subdivision (h) of Section 1206 of the
2 Health and Safety Code, that is not operated by or affiliated with
3 a clinic described in subdivision (b) of Section 1206 of the Health
4 and Safety Code.
- 5 (ii) A community clinic licensed under subdivision (a) of Section
6 1204 of the Health and Safety Code, and any associated intermittent
7 clinic exempt from licensure under subdivision (h) of Section 1206
8 of the Health and Safety Code.
- 9 (iii) A rural health clinic, as defined in paragraph (1) of
10 subdivision (l) of Section 1396d of Title 42 of the United States
11 Code, that is not license-exempt.
- 12 (iv) An urgent care clinic that is owned by or affiliated with a
13 facility defined in clause (ii) or (iii).
- 14 (B) (i) From July 1, 2024, to June 30, 2026, inclusive,
15 twenty-one dollars (\$21) per hour.
- 16 (ii) From July 1, 2026, to June 30, 2027, inclusive, twenty-two
17 dollars (\$22) per hour.
- 18 (iii) From July 1, 2027, and until adjusted by subdivision (d),
19 twenty-five dollars (\$25) per hour.
- 20 (4) For all other covered health care facility employers, the
21 minimum wage for all covered health care employees shall be as
22 follows:
- 23 (A) From July 1, 2024, to June 30, 2026, inclusive, twenty-one
24 dollars (\$21) per hour.
- 25 (B) From July 1, 2026, to June 30, 2028, inclusive, twenty-three
26 dollars (\$23) per hour.
- 27 (C) From July 1, 2028, and until adjusted pursuant to subdivision
28 (d), twenty-five dollars (\$25) per hour.
- 29 (5) Notwithstanding any other provision of this subdivision, a
30 covered health care facility that is county owned, affiliated, or
31 operated shall not be required to comply with this subdivision
32 before January 1, 2025. Commencing January 1, 2025, a covered
33 health care facility that is county owned, affiliated, or operated
34 shall comply with the appropriate schedule described in this
35 subdivision.
- 36 (d) (1) Following the implementation of the minimum wage
37 increase specified in *the following portions of subdivision (c)*:
38 subparagraph (C) of paragraph (1), subparagraph (B) of paragraph
39 (2), clause (iii) of subparagraph (B) of paragraph (3), or
40 subparagraph (C) of paragraph ~~(4) of subdivision (e)~~, (4), on or

1 before August 1 of the following year, and on or before each
2 August 1 thereafter, the Director of Finance shall calculate an
3 adjusted minimum wage. The calculation shall increase the health
4 care worker minimum wage by the lesser of 3.5 percent or the rate
5 of change in the averages of the most recent July 1 to June 30,
6 inclusive, period over the preceding July 1 to June 30, inclusive,
7 period for the United States Bureau of Labor Statistics
8 nonseasonally adjusted United States Consumer Price Index for
9 Urban Wage Earners and Clerical Workers (U.S. CPI-W). The
10 result shall be rounded to the nearest ten cents (\$0.10). Each
11 adjusted health care worker minimum wage increase calculated
12 under this subdivision shall take effect on the following January
13 1.

14 (2) If the rate of change in the averages of the most recent July
15 1 to June 30, inclusive, period over the preceding July 1 to June
16 30, inclusive, period for the United States Bureau of Labor
17 Statistics nonseasonally adjusted U.S. CPI-W is negative, there
18 shall be no increase or decrease in the health care worker minimum
19 wage pursuant to this subdivision on the following January 1.

20 (e) The health care worker minimum wages shall constitute the
21 state minimum wages for covered health care employment for all
22 purposes under this code and the ~~Wage Orders~~ *wage orders* of the
23 Industrial Welfare Commission.

24 (f) (1) A health care worker minimum wage shall be enforceable
25 by the Labor Commissioner *through the procedures set forth in*
26 *Section 98, 98.1, 98.2, 98.3, 98.7, 98.74, or 1197.1*, or by a covered
27 worker through a civil action, through the same means and with
28 the same relief available for violation of any other state minimum
29 wage requirement.

30 (2) (A) *The Department of Industrial Relations shall amend,*
31 *supplement, and republish the Industrial Welfare Commission's*
32 *wage orders to be consistent with this section. The Department of*
33 *Industrial Relations shall not make other changes to the wage*
34 *orders of the Industrial Welfare Commission that are in existence*
35 *on the effective date of this section. The Department of Industrial*
36 *Relations shall meet the requirements set forth in Section 1183.*

37 (B) *Every employer that is subject to this section shall comply*
38 *with both of the following:*

39 (i) *Post a copy of the order as amended, supplemented and*
40 *republished by the Department of Industrial Relations under this*

1 *section and keep it posted in a conspicuous location frequented*
2 *by employees during the hours of the workday, as required by*
3 *Section 1183.*

4 *(ii) Provide to each employee on the effective date of the earliest*
5 *minimum wage increase pursuant to subdivision (c), a written*
6 *notice, in the language the employer normally uses to communicate*
7 *employment-related information to the employee, indicating the*
8 *paragraph of subdivision (c) that applies to the employer and the*
9 *health care worker minimum wage schedule applicable to the*
10 *employee.*

11 *(C) Notwithstanding paragraph (6) of subdivision (h), any*
12 *amendment, supplement, and republication pursuant to this section*
13 *shall be exempt from the rulemaking provisions of the*
14 *Administrative Procedure Act (Chapter 3.5 (commencing with*
15 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
16 *Code), and from the procedures set forth in Sections 1177, 1178.5,*
17 *1181, 1182, and 1182.1.*

18 *(g) For covered health care employment where the compensation*
19 *of the employee is on a salary basis, the employee shall earn a*
20 *monthly salary equivalent to no less than 150 percent of the health*
21 *care worker minimum wage or 200 percent of the minimum wage,*
22 *as described in Section 1182.12, whichever is greater, for full-time*
23 *employment in order to qualify as exempt from the payment of*
24 *minimum wage and overtime under the law of this state, including*
25 *where the employer is the state, a political subdivision of the state,*
26 *a health care district, the University of California, or a*
27 *municipality.*

28 *(h) (1) On or before January 31, 2024, the Department of Health*
29 *Care Access and Information shall publish the following*
30 *information on their internet website:*

31 *(A) A list of all covered health care facility employers with*
32 *10,000 or more full-time equivalent employees, or covered health*
33 *care facility employers that are a part of an integrated health care*
34 *delivery system or health care system with 10,000 or more full-time*
35 *equivalent employee, as defined in this section. employees. This*
36 *list shall only include those covered health care facility employers*
37 *included in the Department of Health Care Access and*
38 *Information's 2021 Pivot Table – Hospital Annual Selected File*
39 *(April 2023 Extract) and published online at*
40 *<https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables>.*

1 *For purposes of determining the number of full-time equivalent*
2 *employees under this subparagraph, published data in the pivot*
3 *table shall be aggregated to determine the total full-time equivalent*
4 *employees for an integrated health care delivery system or health*
5 *system.*

6 (B) A list of all hospitals that qualify as a hospital with a high
7 governmental payor mix, independent hospital with an elevated
8 governmental payor mix, or a rural independent covered health
9 care facility. *This list shall only include those covered health care*
10 *facility employers included in the Department of Health Care*
11 *Access and Information’s 2021 Pivot Table – Hospital Annual*
12 *Selected File (April 2023 Extract) and published online at*
13 *<https://data.chhs.ca.gov/dataset/hospital-annual-financial-data-selected-data-pivot-tables>.*
14 *For purposes of determining the number of full-time equivalent*
15 *employees under this subparagraph, published data in the pivot*
16 *table shall be aggregated to determine the total full-time equivalent*
17 *employees for an integrated health care delivery system or health*
18 *system.*

19 (2) If a covered health care facility believes that they were
20 inappropriately excluded from the list of hospitals that qualify as
21 a hospital with a high governmental payor mix, independent
22 hospital with an elevated governmental payor mix, or a rural
23 independent covered health care facility, the health facility may
24 file a request with the Department of Health Care Access and
25 Information to be classified as a hospital with a high governmental
26 payor mix, independent hospital with an elevated governmental
27 payor mix, or a rural independent covered health care facility. The
28 requesting hospital shall provide the following:

29 (A) The physical location of the requesting hospital.

30 (B) The *revised Annual Disclosure Report pursuant to Section*
31 *128755 of the Health and Safety Code that reflects the payor mix*
32 *of the requesting hospital, including the percent of uninsured*
33 *patients and patients covered by Medi-Cal and Medicare.*

34 (C) Any other information as determined necessary by the
35 Department of Health Care Access and Information.

36 (3) The Department of Health Care Access and Information
37 shall classify a requesting hospital as a hospital with a high
38 governmental payor mix, independent hospital with an elevated
39 governmental payor mix, or a rural independent covered health
40 care facility if they meet the definitions provided under this section.

1 (4) The rules and regulations process described in paragraph
2 (6) shall require the Department of Health Care Access and
3 Information to consider input by stakeholders including health
4 care employees, their representatives, consumers, and health care
5 employers as to the accuracy of the classification of covered health
6 care facility employers according to the numbers of full-time
7 equivalent employees, system affiliation, payor mix, and any other
8 relevant information.

9 (5) The Department of Health Care Access and Information
10 shall not accept any requests for classification as a hospital with
11 a high governmental payor mix, independent hospital with an
12 elevated governmental payor mix, or a rural independent covered
13 health care facility after January 31, 2025.

14 (6) Until January 1, 2025, any necessary rules and regulations
15 for the purpose of implementing this section may be adopted as
16 emergency regulations in accordance with the Administrative
17 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
18 Part 1 of Division 3 of Title 2 of the Government Code). The
19 adoption of emergency regulations pursuant to this section shall
20 be deemed to be an emergency and necessary for the immediate
21 preservation of the public peace, health and safety, or general
22 welfare.

23 (i) (1) ~~No later than March 1, 2024, the~~ *The* Department of
24 Industrial Relations shall, in collaboration with ~~the State~~
25 ~~Department of Health Care Services and the Department of Health~~
26 ~~Care Access and Information, develop~~ *administer* a waiver program
27 for covered health care facilities described in clauses (i) to (iv),
28 inclusive, of subparagraph (A) of paragraph (3) of subdivision (c),
29 ~~which would authorize~~ *will allow* a covered health care facility to
30 ~~apply for and receive a temporary pause or alternative phase a~~
31 ~~12-month delay~~ in schedule of the health care minimum wage
32 requirements in this section. The issuance of ~~the terms of the pause~~
33 ~~or alternative phase in schedule~~ *waivers* pursuant to this subdivision
34 shall be solely and exclusively within the authority of the
35 Department of Industrial Relations, ~~and the~~ *Relations pursuant to*
36 *paragraph (3). The* authority regarding whether the covered health
37 care facility demonstrates ~~the inability to continue as a going~~
38 ~~concern pursuant to that it meets the requirements to obtain a~~
39 ~~waiver, set forth in paragraphs (2) and (3)~~ shall be solely and
40 exclusively within the authority of the ~~State Department of Health~~

1 Care Services. A waiver issued pursuant to this subdivision shall
2 be for a term of one year from the date of issuance. *Department*
3 *of Health Care Access and Information.*

4 (2) In order to obtain a waiver, a covered health care facility
5 shall demonstrate that compliance with this section would raise
6 doubts about the covered health care facility's ability to continue
7 as a going concern under generally accepted accounting principles.
8 The evidence must include documentation of the covered health
9 care facility's financial condition, as well as the condition of any
10 parent or affiliated entity, and evidence of the actual or potential
11 direct financial impact of compliance with this section. *at the time*
12 *the waiver application is submitted that it meets the criteria as set*
13 *forth in subparagraphs (A) and (B) of this paragraph.*

14 (3) Consideration of a covered health care facility's ability to
15 continue as a going concern shall include the following factors
16 regarding the covered health care facility or any affiliated entity:

17 (A) Actual or likely closure of the covered health care facility
18 or any affiliated entity.

19 (B) Actual or likely closure of patient services or programs.

20 (C) Actual or likely loss of jobs.

21 (D) Whether the covered health care facility is small, rural,
22 frontier, or serves a rural catchment area.

23 (E) Whether closure of the covered health care facility would
24 significantly impact access to services in the region or service area.

25 (F) Whether the covered health care facility is in financial
26 distress that results or is likely to result in the closure of the covered
27 health care facility or any affiliated entity, closure of patient
28 services or programs, or loss of jobs. Factors to consider in
29 determining financial distress include, but are not limited to, the
30 covered health care facility's prior and projected performance on
31 financial metrics, including the amount of cash on hand, and
32 whether the covered health care facility has, or is projected to
33 experience negative operating margins.

34 (4) Requests for a waiver pursuant to this subdivision shall be
35 submitted in writing to the Department of Industrial Relations.

36 (5) The Department of Industrial Relations shall coordinate with
37 the State Department of Health Care Services for consideration of
38 the waiver request pursuant to the authorities described in
39 paragraph (1)

1 ~~(6) The Department of Industrial Relations shall notify the~~
2 ~~covered health care facility of the decision on the waiver request~~
3 ~~in writing.~~

4 ~~(7) A covered health care facility may apply to renew a waiver~~
5 ~~issued pursuant to this subdivision at any time no less than 180~~
6 ~~days before the expiration of the existing waiver. The process for~~
7 ~~consideration and issuance of a waiver renewal shall follow the~~
8 ~~process described in paragraphs (4) to (6), inclusive.~~

9 *(A) Each request for a waiver shall include the covered health*
10 *care facility's, and any parent or affiliated company's, most recent*
11 *audited financial statements and year-to-date internally prepared*
12 *financial statements no older than 45 days prior to the date of*
13 *submission; examined level forecasting with an attestation from*
14 *an independent certified public accountant demonstrating that*
15 *compliance with this section would raise doubt about the covered*
16 *health care facility's and its parent company's ability to maintain*
17 *a positive cashflow over the next 12 months; and balance sheets*
18 *showing that the covered health care facility and its parent*
19 *company have less than 45 days cash on hand and a current ratio*
20 *of current assets to current liabilities of one or less.*

21 *(B) The covered health care facility shall provide a declaration*
22 *verifying that the contents of the documents contained in the waiver*
23 *request are true and correct. The declaration shall be in a form*
24 *and manner specified by the Department of Health Care Access*
25 *and Information and signed by an authorized executive officer of*
26 *the covered health care facility.*

27 *(C) The Department of Industrial Relations shall make approved*
28 *information available on its internet website within 15 working*
29 *days of the issuance of the waiver. The Department of Health Care*
30 *Access and Information shall make the audited financial*
31 *information submitted in conjunction with an approved waiver*
32 *available on its internet website within 15 working days of the*
33 *issuance of the waiver.*

34 *(3) If, following review of the documentation submitted pursuant*
35 *to subparagraphs (A) and (B) of paragraph (2), the Department*
36 *of Health Care Access and Information determines that the covered*
37 *health care facility has demonstrated that it meets the criteria for*
38 *a waiver set forth in subdivision (i), the Department of Industrial*
39 *Relations shall issue a waiver for the covered health care facility.*
40 *If a covered health care facility is issued a waiver, all dates in*

1 *clauses (i) to (iii), inclusive, of subparagraph (B) of paragraph*
2 *(3) of subdivision (c), or any superseding dates pursuant to a*
3 *previously issued waiver that are on or after the effective date of*
4 *the issued waiver, are postponed by 12 months for that covered*
5 *health care facility.*

6 *(4) Notwithstanding the rulemaking provisions of the*
7 *Administrative Procedure Act (Chapter 3.5 (commencing with*
8 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
9 *Code), the Department of Industrial Relations and the Department*
10 *of Health Care Access and Information may implement, interpret,*
11 *or make specific this subdivision, in whole or in part, by means of*
12 *information notices or other similar instructions, without taking*
13 *any further regulatory action.*

14 *(5) If a waiver is issued, any covered health care facility affected*
15 *by the waiver shall within 10 days of notice from the Department*
16 *of Industrial Relations:*

17 *(A) Post a copy of the waiver, including the applicable minimum*
18 *wage, in a conspicuous location frequented by employees during*
19 *the hours of the workday.*

20 *(B) Provide to each covered health care employee, a written*
21 *notice, in the language the covered health care facility normally*
22 *uses to communicate employment-related information to the*
23 *covered health care employee, informing the covered health care*
24 *employee the covered health care facility had applied for and*
25 *received a one-year waiver of the increase of the minimum wage*
26 *and stating the applicable minimum wage.*

27 *(6) A covered health care facility may apply for and be issued*
28 *a waiver pursuant to this subdivision in consecutive years.*
29 *However, a waiver shall not be available after July 1, 2032, and*
30 *every covered health care facility described in clauses (i) to (iv),*
31 *inclusive, of subparagraph (A) of paragraph (3) of subdivision (c)*
32 *shall pay the adjusted wage required by subdivision (d) beginning*
33 *July 1, 2033, regardless of whether the facility received any*
34 *waivers.*

35 ~~(8)~~

36 *(7) A waiver issued pursuant to this subdivision shall not exempt*
37 *a covered health care facility from complying with any and all*
38 *federal, state, or local laws and regulations, except to the extent*
39 *that such local laws and regulations are preempted in accordance*
40 *with subdivision (j).*

1 ~~(9)~~

2 (8) Notwithstanding paragraph (3) of subdivision (b), for
3 purposes of this subdivision only, “covered health care facility”
4 shall mean the clinics described in clauses (i) to (iv), inclusive, of
5 subparagraph (A) of paragraph (3) of subdivision (c).

6 (j) (1) An ordinance, regulation, or administrative action
7 applicable to a covered health care facility, as defined in this
8 section, that establishes, requires, imposes, limits, or otherwise
9 relates to wages or compensation for covered health care facility
10 employees, as defined in this section, shall not be enacted or
11 enforced in or by any city, county, city and county, including
12 charter cities, charter counties, and charter cities and counties.

13 (2) Any ordinance, regulation, or administrative action taken
14 by any city, county, or city and county, including charter cities,
15 charter counties, and charter cities and counties, that is enacted or
16 takes effect after September 6, 2023, related to covered health
17 facilities, that establishes, requires, imposes, limits, or otherwise
18 relates to wages, salaries, or compensation for covered health care
19 facility employees, as defined in this section, is void.

20 (3) This subdivision does not preclude any employer, including
21 a city, county, city and county, including charter cities, charter
22 counties, and charter cities and counties, that employs health care
23 employees, from establishing higher wage, salary, or compensation
24 rates for its employees or contracted or subcontracted employees.

25 (4) This subdivision does not preclude a city, county, city and
26 county, including charter cities, charter counties, and charter cities
27 and counties from establishing a minimum wage that would apply
28 uniformly to all employees across all industries and sectors and
29 not exclusively to employees employed by covered health care
30 facilities.

31 (5) This subdivision does not preclude a city, county, city and
32 county, including charter cities, charter counties, and charter cities
33 and counties, from establishing or enforcing a minimum wage
34 applicable to covered health care facility employees, as defined in
35 this section, after January 1, 2034. Any such ordinance, regulation,
36 or administrative action shall be evaluated under ordinary
37 preemption principles.

38 (6) This subdivision does not preclude a city, county, city and
39 county, including charter cities, charter counties, and charter cities
40 and counties, from enacting an ordinance or regulation, or taking

1 administrative action, limiting or otherwise relating to
2 compensation for covered health care facility employees, as defined
3 in this section, after January 1, 2030. Any such ordinance,
4 regulation, or administrative action shall be evaluated under
5 ordinary preemption principles.

6 (7) This subdivision shall be effective only if the provisions of
7 this section that require health care worker minimum wages take
8 effect.

9 (k) *For purposes of implementing this section, the Department*
10 *of Industrial Relations and the Department of Health Care Access*
11 *and Information may enter into exclusive or nonexclusive contracts,*
12 *or amend existing contracts, on a bid or negotiated basis. Contracts*
13 *entered into or amended pursuant to this subdivision shall be*
14 *exempt from Chapter 6 (commencing with Section 14825) of Part*
15 *5.5 of Division 3 of Title 2 of the Government Code, Section 19130*
16 *of the Government Code, Part 2 (commencing with Section 10100)*
17 *of Division 2 of the Public Contract Code, and the State*
18 *Administrative Manual, and shall be exempt from the review or*
19 *approval of any division of the Department of General Services.*

20 SEC. 28. *Section 1182.15 of the Labor Code is amended to*
21 *read:*

22 1182.15. (a) The Legislature finds and declares as follows:

23 (1) Workers in the health care industry, including workers at
24 general acute care hospitals, acute psychiatric hospitals, medical
25 offices and clinics, behavioral health centers, and residential care
26 centers provide vital health care services to California residents,
27 including emergency care, labor and delivery, cancer treatments,
28 and primary and specialty care. Similarly, dialysis clinics provide
29 life-preserving care to patients with end-stage renal disease and
30 are part of the continuum of kidney care that also includes hospitals
31 and health systems. Residents and visitors to the state rely on access
32 to this high-quality health care.

33 (2) Higher wages are an important means of retaining an
34 experienced workforce and attracting new workers. A stable
35 workforce benefits patients and improves quality of care.

36 (3) Employers across multiple industries are raising wages. The
37 health care sector in California must offer higher wages to remain
38 competitive.

39 (4) Members of the health care team such as certified nursing
40 assistants, patient aides, technicians, and food service workers,

1 among many others, are essential to both routine medical care and
2 emergency response efforts.

3 (5) Even before the COVID-19 pandemic, California was facing
4 an urgent and immediate shortage of health care workers, adversely
5 impacting the health and well-being of Californians, especially
6 economically disadvantaged Californians. The pandemic has
7 worsened these shortages. Higher wages are needed to attract and
8 retain health care workers to treat patients, including being prepared
9 to provide necessary care in an emergency.

10 (6) The Legislature finds and declares that laws that establish,
11 require, impose, limit or otherwise relate to wages, salary, or
12 compensation affect access to quality health care for all residents
13 of, and visitors to, the state provided by licensed health care
14 facilities, which serve as a critical part of the state’s ability to
15 respond to catastrophic emergencies. The Legislature also finds
16 and declares that the time limitations and other provisions
17 established by this section are necessary to stabilize the health care
18 system following the state and federal public health emergencies
19 related to COVID-19, the closure and bankruptcy of licensed health
20 care facilities, and the reduction in vital services by licensed health
21 care facilities due to financial distress and the health care workforce
22 crisis that has resulted in staffing shortages and strain for health
23 care workers. The Legislature further finds and declares that access
24 to quality health care and the stability of the health care system is
25 a matter of statewide concern and is not a municipal affair as that
26 term is used in Section 5 of Article XI of the California
27 Constitution. Therefore, this section occupies the whole field of
28 wages, salary, or compensation for covered health care facility
29 employees, and applies to all cities and counties, including charter
30 cities, charter counties, and charter cities and counties during the
31 stabilization period provided by this section.

32 (7) *The Legislature finds and declares that it is the intent of the*
33 *Legislature that subclause (I) of clause (ii) of subparagraph (B)*
34 *of paragraph (2) of subdivision (b) of this section is declarative*
35 *of existing law.*

36 (b) As used in this section:

37 (1) (A) “Covered health care employee” means any of the
38 following:

39 (i) An employee of a health care facility employer who provides
40 patient care, health care services, or services supporting the

1 provision of health care, which includes, but is not limited to,
 2 employees performing work in the occupation of a nurse, physician,
 3 caregiver, medical resident, intern or fellow, patient care technician,
 4 janitor, housekeeping staff person, groundskeeper, guard, clerical
 5 worker, nonmanagerial administrative worker, food service worker,
 6 gift shop worker, technical and ancillary services worker, medical
 7 coding and medical billing personnel, scheduler, call center and
 8 warehouse worker, and laundry worker, regardless of formal job
 9 title.

10 (ii) A contracted or subcontracted employee described in
 11 subparagraph (B).

12 (B) “Covered health care employee” includes a contracted or
 13 subcontracted employee, if ~~all of the following~~ *clauses (i) and (ii)*
 14 apply:

15 (i) The employee’s employer contracts with the *covered* health
 16 care facility employer, or with a contractor or subcontractor to the
 17 *covered* health care facility employer, to provide health care
 18 services, or services supporting the provision of health care.

19 ~~(ii) The (I) Consistent with the definitions of “employ” and~~
 20 ~~“employer” in the Industrial Welfare Commission wage orders,~~
 21 ~~the covered health care facility employer directly or indirectly, or~~
 22 ~~through an agent or any other person, engages, suffers, or permits~~
 23 ~~an employee to work, or exercises control over the employee’s~~
 24 ~~wages, hours or working conditions. However, “covered health~~
 25 ~~care employee” includes all employees performing contracted or~~
 26 ~~subcontracted work primarily on the premises of a health care~~
 27 ~~facility to provide health care services or services supporting the~~
 28 ~~provision of health care. conditions, or~~

29 *(II) The employee performs contracted or subcontracted work*
 30 *primarily on the premises of a covered health care facility. For*
 31 *purposes of this subparagraph, “primarily” means more than*
 32 *one-half of the employee’s work time during a workweek.*

33 *(iii) A contracted or subcontracted employee shall be paid the*
 34 *applicable minimum wage in this section for all hours worked*
 35 *providing patient care, health care services, or services supporting*
 36 *the provision of health care.*

37 (C) Notwithstanding subparagraph (A), “covered health care
 38 employee” does not include:

39 (i) Employment as an outside salesperson.

1 (ii) Any work performed ~~in the public sector where the primary~~
2 ~~duties performed are not health care services: by a public employee~~
3 ~~where the public employee is not primarily engaged in services~~
4 ~~described in clause (i) of subparagraph (A) performed for a~~
5 ~~covered health care facility. For purposes of this subparagraph,~~
6 ~~“primarily” means more than one-half of the employee’s work~~
7 ~~time during a workweek.~~

8 (iii) Delivery or waste collection work on the premises of a
9 covered health care facility, provided that the delivery or waste
10 collection worker is not an employee of any person that owns,
11 controls, or operates a covered health care facility.

12 (iv) Medical transportation services in or out of a covered health
13 care facility, provided that the medical transportation services
14 worker is not an employee of any person that owns, controls, or
15 operates a covered health care facility.

16 (2) (A) “Covered health care facility” means a licensed skilled
17 nursing facility, as defined in subdivision (c) of Section 1250 of
18 the Health and Safety Code, that is not covered by Section 1182.14.

19 (B) “Covered health care facility” does not include either of the
20 following:

21 ~~(i) A skilled nursing facility owned, controlled, or operated by~~
22 ~~the state.~~

23 (i) *A health care facility, as described in subparagraph (A), that*
24 *is owned, controlled, or operated by the state or any state agency*
25 *of the executive branch. As used in this subparagraph, “state*
26 *agency” includes every state office, officer, department, division,*
27 *bureau, board, and commission under the executive branch,*
28 *including any constitutional offices or officers, California State*
29 *University, or California Community College, but does not include*
30 *a health care district or the University of California.*

31 (ii) A tribal clinic exempt from licensure under subdivision (c)
32 of Section 1206 of the Health and Safety Code, or an outpatient
33 setting conducted, maintained, or operated by a federally
34 recognized Indian tribe, tribal organization, or urban Indian
35 organization, as defined in Section 1603 of Title 25 of the United
36 States Code.

37 (3) “Employ” means to engage, suffer, or permit to work.

38 (4) “Employee” means any person employed by an employer.

1 (5) “Employer” means a person who directly or indirectly, or
2 through an agent or any other person, employs or exercises control
3 over the wages, hours, or working conditions of any person.

4 (6) “Health care services” means patient care-related services
5 including nursing; caregiving; services provided by medical
6 residents, interns, or fellows; technical and ancillary services;
7 janitorial work; housekeeping; groundskeeping; guard duties;
8 business office clerical work; food services; laundry; medical
9 coding and billing; call center and warehouse work; scheduling;
10 and gift shop work; but only where such services support patient
11 care.

12 (7) “Health care worker minimum wage” means the minimum
13 wage rate established by this section.

14 (c) For any covered health care facility employer covered by
15 this section, the minimum wage for all covered health care
16 employees shall be as follows:

17 (1) From July 1, 2024, to June 30, 2026, inclusive, twenty-one
18 dollars (\$21) per hour.

19 (2) From July 1, 2026, to June 30, 2028, inclusive, twenty-three
20 dollars (\$23) per hour.

21 (3) From July 1, 2028, and until adjusted pursuant to subdivision
22 (d), twenty-five dollars (\$25) per hour.

23 (d) (1) Following the implementation of the minimum wage
24 increase specified in subdivision (c), on or before August 1 of the
25 following year, and on or before each August 1 thereafter, the
26 Director of Finance shall calculate an adjusted minimum wage.
27 The calculation shall increase the health care worker minimum
28 wage by the lesser of 3.5 percent or the rate of change in the
29 averages of the most recent July 1 to June 30, inclusive, period
30 over the preceding July 1 to June 30, inclusive, period for the
31 United States Bureau of Labor Statistics nonseasonally adjusted
32 United States Consumer Price Index for Urban Wage Earners and
33 Clerical Workers (U.S. CPI-W). The result shall be rounded to the
34 nearest ten cents (\$0.10). Each adjusted health care worker
35 minimum wage increase calculated under this subdivision shall
36 take effect on the following January 1.

37 (2) If the rate of change in the averages of the most recent July
38 1 to June 30, inclusive, period over the preceding July 1 to June
39 30, inclusive, period for the United States Bureau of Labor
40 Statistics nonseasonally adjusted U.S. CPI-W is negative, there

1 shall be no increase or decrease in the health care worker minimum
2 wage pursuant to this subdivision on the following January 1.

3 (e) The health care worker minimum wages shall constitute the
4 state minimum wages for covered health care employment for all
5 purposes under this code and the ~~Wage Orders~~ *wage orders* of the
6 Industrial Welfare Commission.

7 (f) (1) A health care worker minimum wage shall be enforceable
8 by the Labor Commissioner *in accordance with the procedures*
9 *set forth in Section 98, 98.1, 98.2, 98.3, 98.7, 98.74, or 1197.1*, or
10 by a covered worker through a civil action, through the same means
11 and with the same relief available for violation of any other state
12 minimum wage requirement.

13 (2) (A) *The Department of Industrial Relations shall amend,*
14 *supplement, and republish the Industrial Welfare Commission's*
15 *wage orders to be consistent with this section. The Department of*
16 *Industrial Relations shall make no other changes to the wage*
17 *orders of the Industrial Welfare Commission that are in existence*
18 *on the effective date of this section. The Department of Industrial*
19 *Relations shall meet the requirements set forth in Section 1183.*

20 (B) *Every employer that is subject to this section shall comply*
21 *with all of the following:*

22 (i) *Post a copy of the order as amended, supplemented and*
23 *republished by the Department of Industrial Relations under this*
24 *section and keep it posted in a conspicuous location frequented*
25 *by employees during the hours of the workday, as required by*
26 *Section 1183.*

27 (ii) *Provide to each employee on the effective date of the earliest*
28 *minimum wage increase pursuant to subdivision (c), a written*
29 *notice, in the language the employer normally uses to communicate*
30 *employment-related information to the employee, indicating the*
31 *paragraph of subdivision (c) that applies to the employer and the*
32 *health care worker minimum wage schedule applicable to the*
33 *employee.*

34 (C) *Any amendment, supplement, and republication pursuant*
35 *to this section shall be exempt from the rulemaking provisions of*
36 *the Administrative Procedure Act (Chapter 3.5 (commencing with*
37 *Section 11340) of Part 1 of Division 3 of Title 2 of the Government*
38 *Code), and from the procedures set forth in Sections 1177, 1178.5,*
39 *1181, 1182, and 1182.1.*

1 (g) For covered health care employment where the compensation
2 of the employee is on a salary basis, the employee shall earn a
3 monthly salary equivalent to no less than 150 percent of the health
4 care worker minimum wage or 200 percent of the minimum wage,
5 as described in Section 1182.12, whichever is greater, for full-time
6 employment in order to qualify as exempt from the payment of
7 minimum wage and overtime under the law of this state, including
8 where the employer is ~~the state~~, a political subdivision of the state,
9 *a health care district*, the University of California, or a
10 municipality.

11 (h) (1) An ordinance, regulation, or administrative action
12 applicable to a covered health care facility, as defined in this
13 section, that establishes, requires, imposes, limits, or otherwise
14 relates to wages or compensation for covered health care facility
15 employees, as defined in this section, shall not be enacted or
16 enforced in or by any city, county, city and county, including
17 charter cities, charter counties, and charter cities and counties.

18 (2) Any ordinance, regulation, or administrative action taken
19 by any city, county, or city and county, including charter cities,
20 charter counties, and charter cities and counties, that is enacted or
21 takes effect after September 6, 2023, related to covered health
22 facilities, that establishes, requires, imposes, limits, or otherwise
23 relates to wages, salaries, or compensation for covered health care
24 facility employees, as defined in this section, is void.

25 (3) This subdivision does not preclude any employer, including
26 a city, county, city and county, including charter cities, charter
27 counties, and charter cities and counties, that employs health care
28 employees, from establishing higher wage, salary, or compensation
29 rates for its employees or contracted or subcontracted employees.

30 (4) This subdivision does not preclude a city, county, city and
31 county, including charter cities, charter counties, and charter cities
32 and counties from establishing a minimum wage that would apply
33 uniformly to all employees across all industries and sectors and
34 not exclusively to employees employed by covered health care
35 facilities.

36 (5) This subdivision does not preclude a city, county, city and
37 county, including charter cities, charter counties, and charter cities
38 and counties, from establishing or enforcing a minimum wage
39 applicable to covered health care facility employees, as defined in
40 this section, after January 1, 2034. Any such ordinance, regulation,

1 or administrative action shall be evaluated under ordinary
2 preemption principles.

3 (6) This subdivision does not preclude a city, county, city and
4 county, including charter cities, charter counties, and charter cities
5 and counties, from enacting an ordinance or regulation, or taking
6 administrative action, limiting or otherwise relating to
7 compensation for covered health care facility employees, as defined
8 in this section, after January 1, 2030. Any such ordinance,
9 regulation, or administrative action shall be evaluated under
10 ordinary preemption principles.

11 (7) This subdivision shall take effect only if subdivision (c)
12 takes effect.

13 (i) This section shall only take effect when a patient care
14 minimum spending requirement applicable to skilled nursing
15 facilities, as covered in this section, is in effect.

16 *SEC. 29. Section 1182.16 is added to the Labor Code, to read:*

17 *1182.16. Notwithstanding subdivision (c) of Section 1182.14*
18 *and subdivision (c) of Section 1182.15, the effective dates of the*
19 *minimum wage increases required by subparagraph (A) of*
20 *paragraph (1) of subdivision (c), subparagraph (A) of paragraph*
21 *(2) of subdivision (c), clause (i) of subparagraph (B) of paragraph*
22 *(3) of subdivision (c), and subparagraph (A) of paragraph (4) of*
23 *subdivision (c) of Section 1182.14 and paragraph (1) of subdivision*
24 *(c) of Section 1182.15 shall be delayed until either subdivision (a)*
25 *or (b) occur:*

26 *(a) (1) If, on or before October 15, 2024, the Director of Finance*
27 *notifies the Joint Legislative Budget Committee that the Department*
28 *of Finance has determined that agency cash receipts for the period*
29 *from July 1, 2024, through September 30, 2024, are at least 3*
30 *percent higher than the agency cash receipts projected at the time*
31 *the 2024 Budget Act was enacted for the July 1, 2024, through*
32 *September 30, 2024 period, based on current law as of the 2024*
33 *Budget Act, the minimum wage increases set forth in subparagraph*
34 *(A) of paragraph (1) of subdivision (c), subparagraph (A) of*
35 *paragraph (2) of subdivision (c), clause (i) of subparagraph (B)*
36 *of paragraph (3) of subdivision (c), and subparagraph (A) of*
37 *paragraph (4) of subdivision (c) of Section 1182.14 and paragraph*
38 *(1) of subdivision (c) of Section 1182.15 shall be effective October*
39 *15, 2024.*

1 (2) For purposes of this subdivision, “agency cash receipts”
2 means the total amount of the following:

3 (A) Amounts received under Parts 10, 10.2, and 11 of Division
4 2 of the Revenue and Taxation Code, that are reported by the
5 Franchise Tax Board to the Department of Finance as total net
6 collections, excluding elective tax payments pursuant to Part 10.4
7 of Division 2 of the Revenue and Taxation Code, pursuant to law,
8 regulation, procedure, and practice (commonly referred to as the
9 “102 Report”) in effect on the effective date of the act establishing
10 this section.

11 (B) Sales and use tax net cash receipts, as reported by the
12 California Department of Tax and Fee Administration.

13 (b) If the State Department of Health Care Services notifies the
14 Joint Legislative Budget Committee that it has initiated the data
15 retrieval required in accordance with subdivision (b) of Section
16 14169.59 of the Welfare and Institutions Code necessary to
17 implement an increase to hospital quality assurance fee revenues
18 for the program period beginning on January 1, 2025, in
19 accordance with Article 5.230 (commencing with Section 14169.50)
20 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions
21 Code, which would fund increases to supplemental Medi-Cal
22 program payments to hospitals that will provide significant new
23 revenues to hospitals and could support hospitals in complying
24 with, and partially mitigate Medi-Cal program costs of, Sections
25 1182.14 and 1182.15, the minimum wage increases set forth in
26 subparagraph (A) of paragraph (1) of subdivision (c),
27 subparagraph (A) of paragraph (2) of subdivision (c), clause (i)
28 of subparagraph (B) of paragraph (3) of subdivision (c), and
29 subparagraph (A) of paragraph (4) of subdivision (c) of Section
30 1182.14 and paragraph (1) of subdivision (c) of Section 1182.15
31 shall be effective the earlier of January 1, 2025, or 15 days after
32 the date of the State Department of Health Care Service’s
33 notification to the Joint Legislative Budget Committee.

34 SEC. 30. Section 1001.36 of the Penal Code, as added by
35 Section 1.2 of Chapter 687 of the Statutes of 2023, is amended to
36 read:

37 1001.36. (a) On an accusatory pleading alleging the
38 commission of a misdemeanor or felony offense not set forth in
39 subdivision (d), the court may, in its discretion, and after
40 considering the positions of the defense and prosecution, grant

1 pretrial diversion to a defendant pursuant to this section if the
2 defendant satisfies the eligibility requirements for pretrial diversion
3 set forth in subdivision (b) and the court determines that the
4 defendant is suitable for that diversion under the factors set forth
5 in subdivision (c).

6 (b) A defendant is eligible for pretrial diversion pursuant to this
7 section if both of the following criteria are met:

8 (1) The defendant has been diagnosed with a mental disorder
9 as identified in the most recent edition of the Diagnostic and
10 Statistical Manual of Mental Disorders, including, but not limited
11 to, bipolar disorder, schizophrenia, schizoaffective disorder, or
12 post-traumatic stress disorder, but excluding antisocial personality
13 disorder and pedophilia. Evidence of the defendant's mental
14 disorder shall be provided by the defense and shall include a
15 diagnosis or treatment for a diagnosed mental disorder within the
16 last five years by a qualified mental health expert. In opining that
17 a defendant suffers from a qualifying disorder, the qualified mental
18 health expert may rely on an examination of the defendant, the
19 defendant's medical records, arrest reports, or any other relevant
20 evidence.

21 (2) The defendant's mental disorder was a significant factor in
22 the commission of the charged offense. If the defendant has been
23 diagnosed with a mental disorder, the court shall find that the
24 defendant's mental disorder was a significant factor in the
25 commission of the offense unless there is clear and convincing
26 evidence that it was not a motivating factor, causal factor, or
27 contributing factor to the defendant's involvement in the alleged
28 offense. A court may consider any relevant and credible evidence,
29 including, but not limited to, police reports, preliminary hearing
30 transcripts, witness statements, statements by the defendant's
31 mental health treatment provider, medical records, records or
32 reports by qualified medical experts, or evidence that the defendant
33 displayed symptoms consistent with the relevant mental disorder
34 at or near the time of the offense.

35 (c) For any defendant who satisfies the eligibility requirements
36 in subdivision (b), the court must consider whether the defendant
37 is suitable for pretrial diversion. A defendant is suitable for pretrial
38 diversion if all of the following criteria are met:

39 (1) In the opinion of a qualified mental health expert, the
40 defendant's symptoms of the mental disorder causing, contributing

1 to, or motivating the criminal behavior would respond to mental
2 health treatment.

3 (2) The defendant consents to diversion and waives the
4 defendant's right to a speedy trial, unless a defendant has been
5 found to be an appropriate candidate for diversion in lieu of
6 commitment pursuant to clause ~~(iv)~~ (v) of subparagraph (B) of
7 paragraph (1) of subdivision (a) of Section 1370 and, as a result
8 of the defendant's mental incompetence, cannot consent to
9 diversion or give a knowing and intelligent waiver of the
10 defendant's right to a speedy trial.

11 (3) The defendant agrees to comply with treatment as a condition
12 of diversion, unless the defendant has been found to be an
13 appropriate candidate for diversion in lieu of commitment for
14 restoration of competency treatment pursuant to clause ~~(iv)~~ (v) of
15 subparagraph (B) of paragraph (1) of subdivision (a) of Section
16 1370 and, as a result of the defendant's mental incompetence,
17 cannot agree to comply with treatment.

18 (4) The defendant will not pose an unreasonable risk of danger
19 to public safety, as defined in Section 1170.18, if treated in the
20 community. The court may consider the opinions of the district
21 attorney, the defense, or a qualified mental health expert, and may
22 consider the defendant's treatment plan, the defendant's violence
23 and criminal history, the current charged offense, and any other
24 factors that the court deems appropriate.

25 (d) A defendant may not be placed into a diversion program,
26 pursuant to this section, for the following current charged offenses:

27 (1) Murder or voluntary manslaughter.

28 (2) An offense for which a person, if convicted, would be
29 required to register pursuant to Section 290, except for a violation
30 of Section 314.

31 (3) Rape.

32 (4) Lewd or lascivious act on a child under 14 years of age.

33 (5) Assault with intent to commit rape, sodomy, or oral
34 copulation, in violation of Section 220.

35 (6) Commission of rape or sexual penetration in concert with
36 another person, in violation of Section 264.1.

37 (7) Continuous sexual abuse of a child, in violation of Section
38 288.5.

39 (8) A violation of subdivision (b) or (c) of Section 11418.

1 (e) At any stage of the proceedings, the court may require the
2 defendant to make a prima facie showing that the defendant will
3 meet the minimum requirements of eligibility for diversion and
4 that the defendant and the offense are suitable for diversion. The
5 hearing on the prima facie showing shall be informal and may
6 proceed on offers of proof, reliable hearsay, and argument of
7 counsel. If a prima facie showing is not made, the court may
8 summarily deny the request for diversion or grant any other relief
9 as may be deemed appropriate.

10 (f) As used in this chapter, the following terms have the
11 following meanings:

12 (1) “Pretrial diversion” means the postponement of prosecution,
13 either temporarily or permanently, at any point in the judicial
14 process from the point at which the accused is charged until
15 adjudication, to allow the defendant to undergo mental health
16 treatment, subject to all of the following:

17 (A) (i) The court is satisfied that the recommended inpatient
18 or outpatient program of mental health treatment will meet the
19 specialized mental health treatment needs of the defendant.

20 (ii) The defendant may be referred to a program of mental health
21 treatment utilizing existing inpatient or outpatient mental health
22 resources. Before approving a proposed treatment program, the
23 court shall consider the request of the defense, the request of the
24 prosecution, the needs of the defendant, and the interests of the
25 community. The treatment may be procured using private or public
26 funds, and a referral may be made to a county mental health
27 agency, existing collaborative courts, or assisted outpatient
28 treatment only if that entity has agreed to accept responsibility for
29 the treatment of the defendant, and mental health services are
30 provided only to the extent that resources are available and the
31 defendant is eligible for those services.

32 (iii) If the court refers the defendant to a county mental health
33 agency pursuant to this section and the agency determines that it
34 is unable to provide services to the defendant, the court shall accept
35 a written declaration to that effect from the agency in lieu of
36 requiring live testimony. That declaration shall serve only to
37 establish that the program is unable to provide services to the
38 defendant at that time and does not constitute evidence that the
39 defendant is unqualified or unsuitable for diversion under this
40 section.

1 (B) The provider of the mental health treatment program in
2 which the defendant has been placed shall provide regular reports
3 to the court, the defense, and the prosecutor on the defendant's
4 progress in treatment.

5 (C) The period during which criminal proceedings against the
6 defendant may be diverted is limited as follows:

7 (i) If the defendant is charged with a felony, the period shall be
8 no longer than two years.

9 (ii) If the defendant is charged with a misdemeanor, the period
10 shall be no longer than one year.

11 (D) Upon request, the court shall conduct a hearing to determine
12 whether restitution, as defined in subdivision (f) of Section 1202.4,
13 is owed to any victim as a result of the diverted offense and, if
14 owed, order its payment during the period of diversion. However,
15 a defendant's inability to pay restitution due to indigence or mental
16 disorder shall not be grounds for denial of diversion or a finding
17 that the defendant has failed to comply with the terms of diversion.

18 (2) "Qualified mental health expert" includes, but is not limited
19 to, a psychiatrist, psychologist, a person described in Section
20 5751.2 of the Welfare and Institutions Code, or a person whose
21 knowledge, skill, experience, training, or education qualifies them
22 as an expert.

23 (g) If any of the following circumstances exists, the court shall,
24 after notice to the defendant, defense counsel, and the prosecution,
25 hold a hearing to determine whether the criminal proceedings
26 should be reinstated, whether the treatment should be modified,
27 or whether the defendant should be conserved and referred to the
28 conservatorship investigator of the county of commitment to initiate
29 conservatorship proceedings for the defendant pursuant to Chapter
30 3 (commencing with Section 5350) of Part 1 of Division 5 of the
31 Welfare and Institutions Code:

32 (1) The defendant is charged with an additional misdemeanor
33 allegedly committed during the pretrial diversion and that reflects
34 the defendant's propensity for violence.

35 (2) The defendant is charged with an additional felony allegedly
36 committed during the pretrial diversion.

37 (3) The defendant is engaged in criminal conduct rendering the
38 defendant unsuitable for diversion.

1 (4) Based on the opinion of a qualified mental health expert
2 whom the court may deem appropriate, either of the following
3 circumstances exists:

4 (A) The defendant is performing unsatisfactorily in the assigned
5 program.

6 (B) The defendant is gravely disabled, as defined in
7 subparagraph (B) of paragraph (1) of subdivision (h) of Section
8 5008 of the Welfare and Institutions Code. A defendant shall only
9 be conserved and referred to the conservatorship investigator
10 pursuant to this finding.

11 (h) If the defendant has performed satisfactorily in diversion,
12 at the end of the period of diversion, the court shall dismiss the
13 defendant's criminal charges that were the subject of the criminal
14 proceedings at the time of the initial diversion. A court may
15 conclude that the defendant has performed satisfactorily if the
16 defendant has substantially complied with the requirements of
17 diversion, has avoided significant new violations of law unrelated
18 to the defendant's mental health condition, and has a plan in place
19 for long-term mental health care. If the court dismisses the charges,
20 the clerk of the court shall file a record with the Department of
21 Justice indicating the disposition of the case diverted pursuant to
22 this section. Upon successful completion of diversion, if the court
23 dismisses the charges, the arrest upon which the diversion was
24 based shall be deemed never to have occurred, and the court shall
25 order access to the record of the arrest restricted in accordance
26 with Section 1001.9, except as specified in subdivisions (j) and
27 (k). The defendant who successfully completes diversion may
28 indicate in response to any question concerning the defendant's
29 prior criminal record that the defendant was not arrested or diverted
30 for the offense, except as specified in subdivision (j).

31 (i) A record pertaining to an arrest resulting in successful
32 completion of diversion, or any record generated as a result of the
33 defendant's application for or participation in diversion, shall not,
34 without the defendant's consent, be used in any way that could
35 result in the denial of any employment, benefit, license, or
36 certificate.

37 (j) The defendant shall be advised that, regardless of the
38 defendant's completion of diversion, both of the following apply:

39 (1) The arrest upon which the diversion was based may be
40 disclosed by the Department of Justice to any peace officer

1 application request and that, notwithstanding subdivision (i), this
2 section does not relieve the defendant of the obligation to disclose
3 the arrest in response to any direct question contained in any
4 questionnaire or application for a position as a peace officer, as
5 defined in Section 830.

6 (2) An order to seal records pertaining to an arrest made pursuant
7 to this section has no effect on a criminal justice agency's ability
8 to access and use those sealed records and information regarding
9 sealed arrests, as described in Section 851.92.

10 (k) A finding that the defendant suffers from a mental disorder,
11 any progress reports concerning the defendant's treatment,
12 including, but not limited to, any finding that the defendant be
13 prohibited from owning or controlling a firearm because they are
14 a danger to themselves or others pursuant to subdivision (m), or
15 any other records related to a mental disorder that were created as
16 a result of participation in, or completion of, diversion pursuant
17 to this section or for use at a hearing on the defendant's eligibility
18 for diversion under this section may not be used in any other
19 proceeding without the defendant's consent, unless that information
20 is relevant evidence that is admissible under the standards described
21 in paragraph (2) of subdivision (f) of Section 28 of Article I of the
22 California Constitution. However, when determining whether to
23 exercise its discretion to grant diversion under this section, a court
24 may consider previous records of participation in diversion under
25 this section.

26 (l) The county agency administering the diversion, the
27 defendant's mental health treatment providers, the public guardian
28 or conservator, and the court shall, to the extent not prohibited by
29 federal law, have access to the defendant's medical and
30 psychological records, including progress reports, during the
31 defendant's time in diversion, as needed, for the purpose of
32 providing care and treatment and monitoring treatment for
33 diversion or conservatorship.

34 (m) (1) The prosecution may request an order from the court
35 that the defendant be prohibited from owning or possessing a
36 firearm until they successfully complete diversion because they
37 are a danger to themselves or others pursuant to subdivision (i) of
38 Section 8103 of the Welfare and Institutions Code.

39 (2) The prosecution shall bear the burden of proving, by clear
40 and convincing evidence, both of the following are true:

1 (A) The defendant poses a significant danger of causing personal
2 injury to themselves or another by having in their custody or
3 control, owning, purchasing, possessing, or receiving a firearm.

4 (B) The prohibition is necessary to prevent personal injury to
5 the defendant or any other person because less restrictive
6 alternatives either have been tried and found to be ineffective or
7 are inadequate or inappropriate for the circumstances of the
8 defendant.

9 (3) (A) If the court finds that the prosecution has not met that
10 burden, the court shall not order that the person is prohibited from
11 having, owning, purchasing, possessing, or receiving a firearm.

12 (B) If the court finds that the prosecution has met the burden,
13 the court shall order that the person is prohibited, and shall inform
14 the person that they are prohibited, from owning or controlling a
15 firearm until they successfully complete diversion because they
16 are a danger to themselves or others.

17 (4) An order imposed pursuant to this subdivision shall be in
18 effect until the defendant has successfully completed diversion or
19 until their firearm rights are restored pursuant to paragraph (4) of
20 subdivision (g) of Section 8103 of the Welfare and Institutions
21 Code.

22 (n) This section shall become operative on July 1, 2024.

23 *SEC. 31. Section 1370 of the Penal Code is amended to read:*

24 1370. (a) (1) (A) If the defendant is found mentally
25 competent, the criminal process shall resume, the trial on the
26 offense charged or hearing on the alleged violation shall proceed,
27 and judgment may be pronounced.

28 (B) If the defendant is found mentally incompetent, the trial,
29 the hearing on the alleged violation, or the judgment shall be
30 suspended until the person becomes mentally competent.

31 (i) The court shall order that the mentally incompetent defendant
32 be delivered by the sheriff to a State Department of State Hospitals
33 facility, as defined in Section 4100 of the Welfare and Institutions
34 Code, as directed by the State Department of State Hospitals, or
35 to any other available public or private treatment facility, including
36 a community-based residential treatment system approved by the
37 community program director, or their designee, that will promote
38 the defendant's speedy restoration to mental competence, or placed
39 on outpatient status as specified in Section 1600.

1 (ii) (I) *If a defendant has been found mentally incompetent, and*
2 *the court has ordered commitment to a State Department of State*
3 *Hospitals facility as described in Section 4100 of the Welfare and*
4 *Institutions Code, and is not in the custody of the local sheriff, the*
5 *department shall inform the sheriff when a placement in a facility*
6 *becomes available and make reasonable efforts to coordinate a*
7 *delivery by the sheriff to transport the defendant to the facility. If*
8 *the department has made reasonable attempts for 90 days, starting*
9 *with the date of commitment, and the defendant has not been*
10 *transported, as originally ordered under clause (i), the department*
11 *shall inform the court and sheriff in writing.*

12 (II) *If the sheriff has not delivered the defendant to a State*
13 *Department of State Hospitals facility within 90 days after the*
14 *department's written notice, the commitment to the State*
15 *Department of State Hospitals shall be automatically stayed and*
16 *the department may remove the defendant from the pending*
17 *placement list until the court notifies the department in writing*
18 *that the defendant is available for transport and the defendant*
19 *shall regain their place on the pending placement list.*

20 (ii)

21 (iii) *However, if the action against the defendant who has been*
22 *found mentally incompetent is on a complaint charging a felony*
23 *offense specified in Section 290, the prosecutor shall determine*
24 *whether the defendant previously has been found mentally*
25 *incompetent to stand trial pursuant to this chapter on a charge of*
26 *a Section 290 offense, or whether the defendant is currently the*
27 *subject of a pending Section 1368 proceeding arising out of a*
28 *charge of a Section 290 offense. If either determination is made,*
29 *the prosecutor shall notify the court and defendant in writing. After*
30 *this notification, and opportunity for hearing, the court shall order*
31 *that the defendant be delivered by the sheriff to a State Department*
32 *of State Hospitals facility, as directed by the State Department of*
33 *State Hospitals, or other secure treatment facility for the care and*
34 *treatment of persons with a mental health disorder, unless the court*
35 *makes specific findings on the record that an alternative placement*
36 *would provide more appropriate treatment for the defendant and*
37 *would not pose a danger to the health and safety of others.*

38 (iii)

39 (iv) *If the action against the defendant who has been found*
40 *mentally incompetent is on a complaint charging a felony offense*

1 specified in Section 290 and the defendant has been denied bail
2 pursuant to subdivision (b) of Section 12 of Article I of the
3 California Constitution because the court has found, based upon
4 clear and convincing evidence, a substantial likelihood that the
5 person's release would result in great bodily harm to others, the
6 court shall order that the defendant be delivered by the sheriff to
7 a State Department of State Hospitals facility, as directed by the
8 State Department of State Hospitals, unless the court makes specific
9 findings on the record that an alternative placement would provide
10 more appropriate treatment for the defendant and would not pose
11 a danger to the health and safety of others.

12 ~~(iv)~~

13 (v) (I) If, at any time after the court finds that the defendant is
14 mentally incompetent and before the defendant is transported to
15 a facility pursuant to this section, the court is provided with any
16 information that the defendant may benefit from diversion pursuant
17 to Chapter 2.8A (commencing with Section 1001.35) of Title 6,
18 the court may make a finding that the defendant is an appropriate
19 candidate for diversion.

20 (II) Notwithstanding subclause (I), if a defendant is found
21 mentally incompetent and is transferred to a facility described in
22 Section 4361.6 of the Welfare and Institutions Code, the court
23 may, at any time upon receiving any information that the defendant
24 may benefit from diversion pursuant to Chapter 2.8A (commencing
25 with Section 1001.35) of Title 6, make a finding that the defendant
26 is an appropriate candidate for diversion.

27 ~~(v)~~

28 (vi) If a defendant is found by the court to be an appropriate
29 candidate for diversion pursuant to clause ~~(iv)~~, (v), the defendant's
30 eligibility shall be determined pursuant to Section 1001.36. A
31 defendant granted diversion may participate for the lesser of the
32 period specified in paragraph (1) of subdivision (c) or the
33 applicable period described in subparagraph (C) of paragraph (1)
34 of subdivision (f) of Section 1001.36. If, during that period, the
35 court determines that criminal proceedings should be reinstated
36 pursuant to subdivision (g) of Section 1001.36, the court shall,
37 pursuant to Section 1369, appoint a psychiatrist, licensed
38 psychologist, or any other expert the court may deem appropriate,
39 to determine the defendant's competence to stand trial.

40 ~~(vi)~~

1 (vii) Upon the dismissal of charges at the conclusion of the
2 period of diversion, pursuant to subdivision (h) of Section 1001.36,
3 a defendant shall no longer be deemed incompetent to stand trial
4 pursuant to this section.

5 ~~(vii)~~

6 (viii) The clerk of the court shall notify the Department of
7 Justice, in writing, of a finding of mental incompetence with respect
8 to a defendant who is subject to clause ~~(ii)~~ or (iii) or (iv) for
9 inclusion in the defendant's state summary criminal history
10 information.

11 (C) Upon the filing of a certificate of restoration to competence,
12 the court shall order that the defendant be returned to court in
13 accordance with Section 1372. The court shall transmit a copy of
14 its order to the community program director or a designee.

15 (D) A defendant charged with a violent felony may not be
16 delivered to a State Department of State Hospitals facility or
17 treatment facility pursuant to this subdivision unless the State
18 Department of State Hospitals facility or treatment facility has a
19 secured perimeter or a locked and controlled treatment facility,
20 and the judge determines that the public safety will be protected.

21 (E) For purposes of this paragraph, "violent felony" means an
22 offense specified in subdivision (c) of Section 667.5.

23 (F) A defendant charged with a violent felony may be placed
24 on outpatient status, as specified in Section 1600, only if the court
25 finds that the placement will not pose a danger to the health or
26 safety of others. If the court places a defendant charged with a
27 violent felony on outpatient status, as specified in Section 1600,
28 the court shall serve copies of the placement order on defense
29 counsel, the sheriff in the county where the defendant will be
30 placed, and the district attorney for the county in which the violent
31 felony charges are pending against the defendant.

32 (G) If, at any time after the court has declared a defendant
33 incompetent to stand trial pursuant to this section, counsel for the
34 defendant or a jail medical or mental health staff provider provides
35 the court with substantial evidence that the defendant's psychiatric
36 symptoms have changed to such a degree as to create a doubt in
37 the mind of the judge as to the defendant's current mental
38 incompetence, the court may appoint a psychiatrist or a licensed
39 psychologist to opine as to whether the defendant has regained
40 competence. If, in the opinion of that expert, the defendant has

1 regained competence, the court shall proceed as if a certificate of
2 restoration of competence has been returned pursuant to paragraph
3 (1) of subdivision (a) of Section 1372.

4 (H) (i) The State Department of State Hospitals may, pursuant
5 to Section 4335.2 of the Welfare and Institutions Code, conduct
6 an evaluation of the defendant in county custody to determine any
7 of the following:

8 (I) The defendant has regained competence.

9 (II) There is no substantial likelihood that the defendant will
10 regain competence in the foreseeable future.

11 (III) The defendant should be referred to the county for further
12 evaluation for potential participation in a county diversion program,
13 if one exists, or to another outpatient treatment program.

14 (ii) If, in the opinion of the department's expert, the defendant
15 has regained competence, the court shall proceed as if a certificate
16 of restoration of competence has been returned pursuant to
17 paragraph (1) of subdivision (a) of Section 1372.

18 (iii) If, in the opinion of the department's expert, there is no
19 substantial likelihood that the defendant will regain mental
20 competence in the foreseeable future, the committing court shall
21 proceed pursuant to paragraph (2) of subdivision (c) no later than
22 10 days following receipt of the report.

23 (2) Prior to making the order directing that the defendant be
24 committed to the State Department of State Hospitals or other
25 treatment facility or placed on outpatient status, the court shall
26 proceed as follows:

27 (A) (i) The court shall order the community program director
28 or a designee to evaluate the defendant and to submit to the court
29 within 15 judicial days of the order a written recommendation as
30 to whether the defendant should be required to undergo outpatient
31 treatment, or be committed to the State Department of State
32 Hospitals or to any other treatment facility. A person shall not be
33 admitted to a State Department of State Hospitals facility or other
34 treatment facility or placed on outpatient status under this section
35 without having been evaluated by the community program director
36 or a designee. The community program director or designee shall
37 evaluate the appropriate placement for the defendant between a
38 State Department of State Hospitals facility or the
39 community-based residential treatment system based upon
40 guidelines provided by the State Department of State Hospitals.

1 (ii) ~~Commencing on July 1, 2023, a~~ A defendant shall first be
2 considered for placement in an outpatient treatment program, a
3 community treatment program, or a diversion program, if any such
4 program is available, unless a court, based upon the
5 recommendation of the community program director or their
6 designee, finds that either the clinical needs of the defendant or
7 the risk to community safety, warrant placement in a State
8 Department of State Hospitals facility.

9 (B) The court shall hear and determine whether the defendant
10 lacks capacity to make decisions regarding the administration of
11 antipsychotic medication. The court shall consider opinions in the
12 reports prepared pursuant to subdivision (a) of Section 1369, as
13 applicable to the issue of whether the defendant lacks capacity to
14 make decisions regarding the administration of antipsychotic
15 medication, and shall proceed as follows:

16 (i) The court shall hear and determine whether any of the
17 following is true:

18 (I) Based upon the opinion of the psychiatrist or licensed
19 psychologist offered to the court pursuant to subparagraph (A) of
20 paragraph (2) of subdivision (a) of Section 1369, the defendant
21 lacks capacity to make decisions regarding antipsychotic
22 medication, the defendant's mental disorder requires medical
23 treatment with antipsychotic medication, and, if the defendant's
24 mental disorder is not treated with antipsychotic medication, it is
25 probable that serious harm to the physical or mental health of the
26 defendant will result. Probability of serious harm to the physical
27 or mental health of the defendant requires evidence that the
28 defendant is presently suffering adverse effects to their physical
29 or mental health, or the defendant has previously suffered these
30 effects as a result of a mental disorder and their condition is
31 substantially deteriorating. The fact that a defendant has a diagnosis
32 of a mental disorder does not alone establish probability of serious
33 harm to the physical or mental health of the defendant.

34 (II) Based upon the opinion of the psychiatrist or licensed
35 psychologist offered to the court pursuant to subparagraph (A) of
36 paragraph (2) of subdivision (a) of Section 1369, the defendant is
37 a danger to others, in that the defendant has inflicted, attempted
38 to inflict, or made a serious threat of inflicting substantial physical
39 harm on another while in custody, or the defendant had inflicted,
40 attempted to inflict, or made a serious threat of inflicting substantial

1 physical harm on another that resulted in the defendant being taken
2 into custody, and the defendant presents, as a result of mental
3 disorder or mental defect, a demonstrated danger of inflicting
4 substantial physical harm on others. Demonstrated danger may be
5 based on an assessment of the defendant's present mental condition,
6 including a consideration of past behavior of the defendant within
7 six years prior to the time the defendant last attempted to inflict,
8 inflicted, or threatened to inflict substantial physical harm on
9 another, and other relevant evidence.

10 (III) The people have charged the defendant with a serious crime
11 against the person or property, and based upon the opinion of the
12 psychiatrist offered to the court pursuant to subparagraph (C) of
13 paragraph (2) of subdivision (a) of Section 1369, the involuntary
14 administration of antipsychotic medication is substantially likely
15 to render the defendant competent to stand trial, the medication is
16 unlikely to have side effects that interfere with the defendant's
17 ability to understand the nature of the criminal proceedings or to
18 assist counsel in the conduct of a defense in a reasonable manner,
19 less intrusive treatments are unlikely to have substantially the same
20 results, and antipsychotic medication is medically necessary and
21 appropriate in light of their medical condition.

22 (ii) (I) If the court finds the conditions described in subclause
23 (I) or (II) of clause (i) to be true, and if pursuant to the opinion
24 offered to the court pursuant to paragraph (2) of subdivision (a)
25 of Section 1369, a psychiatrist has opined that treatment with
26 antipsychotic medications is appropriate for the defendant, the
27 court shall issue an order authorizing the administration of
28 antipsychotic medication as needed, including on an involuntary
29 basis, to be administered under the direction and supervision of a
30 licensed psychiatrist.

31 (II) If the court finds the conditions described in subclause (I)
32 or (II) of clause (i) to be true, and if pursuant to the opinion offered
33 to the court pursuant to paragraph (2) of subdivision (a) of Section
34 1369, a licensed psychologist has opined that treatment with
35 antipsychotic medication may be appropriate for the defendant,
36 the court shall issue an order authorizing treatment by a licensed
37 psychiatrist on an involuntary basis. That treatment may include
38 the administration of antipsychotic medication as needed, to be
39 administered under the direction and supervision of a licensed
40 psychiatrist.

1 (III) If the court finds the conditions described in subclause (III)
2 of clause (i) to be true, and if pursuant to the opinion offered to
3 the court pursuant to paragraph (2) of subdivision (a) of Section
4 1369, a psychiatrist has opined that it is appropriate to treat the
5 defendant with antipsychotic medication, the court shall issue an
6 order authorizing the administration of antipsychotic medication
7 as needed, including on an involuntary basis, to be administered
8 under the direction and supervision of a licensed psychiatrist.

9 (iii) An order authorizing involuntary administration of
10 antipsychotic medication to the defendant when and as prescribed
11 by the defendant's treating psychiatrist at any facility housing the
12 defendant for purposes of this chapter, including a county jail,
13 shall remain in effect when the defendant returns to county custody
14 pursuant to subparagraph (A) of paragraph (1) of subdivision (b)
15 or paragraph (1) of subdivision (c), or pursuant to subparagraph
16 (C) of paragraph (3) of subdivision (a) of Section 1372, but shall
17 be valid for no more than one year, pursuant to subparagraph (A)
18 of paragraph (7). The court shall not order involuntary
19 administration of psychotropic medication under subclause (III)
20 of clause (i) unless the court has first found that the defendant does
21 not meet the criteria for involuntary administration of psychotropic
22 medication under subclause (I) of clause (i) and does not meet the
23 criteria under subclause (II) of clause (i).

24 (iv) In all cases, the treating hospital, county jail, facility, or
25 program may administer medically appropriate antipsychotic
26 medication prescribed by a psychiatrist in an emergency as
27 described in subdivision (m) of Section 5008 of the Welfare and
28 Institutions Code.

29 (v) If the court has determined that the defendant has the
30 capacity to make decisions regarding antipsychotic medication,
31 and if the defendant, with advice of their counsel, consents, the
32 court order of commitment shall include confirmation that
33 antipsychotic medication may be given to the defendant as
34 prescribed by a treating psychiatrist pursuant to the defendant's
35 consent. The commitment order shall also indicate that, if the
36 defendant withdraws consent for antipsychotic medication, after
37 the treating psychiatrist complies with the provisions of
38 subparagraph (C), the defendant shall be returned to court for a
39 hearing in accordance with subparagraphs (C) and (D) regarding

1 whether antipsychotic medication shall be administered
2 involuntarily.

3 (vi) If the court has determined that the defendant has the
4 capacity to make decisions regarding antipsychotic medication
5 and if the defendant, with advice from their counsel, does not
6 consent, the court order for commitment shall indicate that, after
7 the treating psychiatrist complies with the provisions of
8 subparagraph (C), the defendant shall be returned to court for a
9 hearing in accordance with subparagraphs (C) and (D) regarding
10 whether antipsychotic medication shall be administered
11 involuntarily.

12 (vii) A report made pursuant to paragraph (1) of subdivision (b)
13 shall include a description of antipsychotic medication administered
14 to the defendant and its effects and side effects, including effects
15 on the defendant's appearance or behavior that would affect the
16 defendant's ability to understand the nature of the criminal
17 proceedings or to assist counsel in the conduct of a defense in a
18 reasonable manner. During the time the defendant is confined in
19 a State Department of State Hospitals facility or other treatment
20 facility or placed on outpatient status, either the defendant or the
21 people may request that the court review any order made pursuant
22 to this subdivision. The defendant, to the same extent enjoyed by
23 other patients in the State Department of State Hospitals facility
24 or other treatment facility, shall have the right to contact the
25 patients' rights advocate regarding the defendant's rights under
26 this section.

27 (C) If the defendant consented to antipsychotic medication as
28 described in clause (iv) of subparagraph (B), but subsequently
29 withdraws their consent, or, if involuntary antipsychotic medication
30 was not ordered pursuant to clause (v) of subparagraph (B), and
31 the treating psychiatrist determines that antipsychotic medication
32 has become medically necessary and appropriate, the treating
33 psychiatrist shall make efforts to obtain informed consent from
34 the defendant for antipsychotic medication. If informed consent
35 is not obtained from the defendant, and the treating psychiatrist is
36 of the opinion that the defendant lacks capacity to make decisions
37 regarding antipsychotic medication based on the conditions
38 described in subclause (I) or (II) of clause (i) of subparagraph (B),
39 the treating psychiatrist shall certify whether the lack of capacity
40 and any applicable conditions described above exist. That

1 certification shall contain an assessment of the current mental
2 status of the defendant and the opinion of the treating psychiatrist
3 that involuntary antipsychotic medication has become medically
4 necessary and appropriate.

5 (D) (i) If the treating psychiatrist certifies that antipsychotic
6 medication has become medically necessary and appropriate
7 pursuant to subparagraph (C), antipsychotic medication may be
8 administered to the defendant for not more than 21 days, provided,
9 however, that, within 72 hours of the certification, the defendant
10 is provided a medication review hearing before an administrative
11 law judge to be conducted at the facility where the defendant is
12 receiving treatment. The treating psychiatrist shall present the case
13 for the certification for involuntary treatment and the defendant
14 shall be represented by an attorney or a patients' rights advocate.
15 The attorney or patients' rights advocate shall be appointed to meet
16 with the defendant no later than one day prior to the medication
17 review hearing to review the defendant's rights at the medication
18 review hearing, discuss the process, answer questions or concerns
19 regarding involuntary medication or the hearing, assist the
20 defendant in preparing for the hearing and advocating for the
21 defendant's interests at the hearing, review the panel's final
22 determination following the hearing, advise the defendant of their
23 right to judicial review of the panel's decision, and provide the
24 defendant with referral information for legal advice on the subject.
25 The defendant shall also have the following rights with respect to
26 the medication review hearing:

- 27 (I) To be given timely access to the defendant's records.
28 (II) To be present at the hearing, unless the defendant waives
29 that right.
30 (III) To present evidence at the hearing.
31 (IV) To question persons presenting evidence supporting
32 involuntary medication.
33 (V) To make reasonable requests for attendance of witnesses
34 on the defendant's behalf.
35 (VI) To a hearing conducted in an impartial and informal
36 manner.
37 (ii) If the administrative law judge determines that the defendant
38 either meets the criteria specified in subclause (I) of clause (i) of
39 subparagraph (B), or meets the criteria specified in subclause (II)
40 of clause (i) of subparagraph (B), antipsychotic medication may

1 continue to be administered to the defendant for the 21-day
2 certification period. Concurrently with the treating psychiatrist's
3 certification, the treating psychiatrist shall file a copy of the
4 certification and a petition with the court for issuance of an order
5 to administer antipsychotic medication beyond the 21-day
6 certification period. For purposes of this subparagraph, the treating
7 psychiatrist shall not be required to pay or deposit any fee for the
8 filing of the petition or other document or paper related to the
9 petition.

10 (iii) If the administrative law judge disagrees with the
11 certification, medication may not be administered involuntarily
12 until the court determines that antipsychotic medication should be
13 administered pursuant to this section.

14 (iv) The court shall provide notice to the prosecuting attorney
15 and to the attorney representing the defendant, and shall hold a
16 hearing, no later than 18 days from the date of the certification, to
17 determine whether antipsychotic medication should be ordered
18 beyond the certification period.

19 (v) If, as a result of the hearing, the court determines that
20 antipsychotic medication should be administered beyond the
21 certification period, the court shall issue an order authorizing the
22 administration of that medication.

23 (vi) The court shall render its decision on the petition and issue
24 its order no later than three calendar days after the hearing and, in
25 any event, no later than the expiration of the 21-day certification
26 period.

27 (vii) If the administrative law judge upholds the certification
28 pursuant to clause (ii), the court may, for a period not to exceed
29 14 days, extend the certification and continue the hearing pursuant
30 to stipulation between the parties or upon a finding of good cause.
31 In determining good cause, the court may review the petition filed
32 with the court, the administrative law judge's order, and any
33 additional testimony needed by the court to determine if it is
34 appropriate to continue medication beyond the 21-day certification
35 and for a period of up to 14 days.

36 (viii) The district attorney, county counsel, or representative of
37 a facility where a defendant found incompetent to stand trial is
38 committed may petition the court for an order to administer
39 involuntary medication pursuant to the criteria set forth in

1 subclauses (II) and (III) of clause (i) of subparagraph (B). The
 2 order is reviewable as provided in paragraph (7).

3 (3) (A) When the court orders that the defendant be committed
 4 to a State Department of State Hospitals facility or other public or
 5 private treatment facility, the court shall provide copies of the
 6 following documents prior to the admission of the defendant to
 7 the State Department of State Hospitals or other treatment facility
 8 where the defendant is to be committed:

9 ~~(A)~~

10 (i) The commitment order, which shall include a specification
 11 of the charges, an assessment of whether involuntary treatment
 12 with antipsychotic medications is warranted, and any orders by
 13 the court, pursuant to subparagraph (B) of paragraph (2),
 14 authorizing involuntary treatment with antipsychotic medications.

15 ~~(B)~~

16 (ii) A computation or statement setting forth the maximum term
 17 of commitment in accordance with subdivision (c).

18 ~~(C) (i)~~

19 (iii) (I) A computation or statement setting forth the amount of
 20 credit for time served, if any, to be deducted from the maximum
 21 term of commitment.

22 ~~(ii)~~

23 (II) If a certificate of restoration of competency was filed with
 24 the court pursuant to Section 1372 and the court subsequently
 25 rejected the certification, a copy of the court order or minute order
 26 rejecting the certification shall be provided. The court order shall
 27 include a new computation or statement setting forth the amount
 28 of credit for time served, if any, to be deducted from the
 29 defendant's maximum term of commitment based on the court's
 30 rejection of the certification.

31 ~~(D)~~

32 (iv) State summary criminal history information.

33 ~~(E)~~

34 (v) Jail classification records for the defendant's current
 35 incarceration.

36 ~~(F)~~

37 (vi) Arrest reports prepared by the police department or other
 38 law enforcement agency.

39 ~~(G)~~

1 (vii) Court-ordered psychiatric examination or evaluation
2 reports.

3 (H)

4 (viii) The community program director's placement
5 recommendation report.

6 (I)

7 (ix) Records of a finding of mental incompetence pursuant to
8 this chapter arising out of a complaint charging a felony offense
9 specified in Section 290 or a pending Section 1368 proceeding
10 arising out of a charge of a Section 290 offense.

11 (J)

12 (x) Medical records, including jail mental health records.

13 (B) *If a defendant is committed to a State Department of State
14 Hospitals facility, and the department determines that additional
15 medical or mental health treatment records are needed for
16 continuity of care, any private or public entity holding medical or
17 mental health treatment records of that defendant shall release
18 those records upon receiving a written request from the State
19 Department of State Hospitals within 10 calendar days after the
20 request. The private or public entity holding the medical or mental
21 health treatment records shall comply with all applicable federal
22 and state privacy laws prior to disclosure. The State Department
23 of State Hospitals shall not release records obtained during the
24 admission process under this subdivision, pursuant to Section
25 1798.68 of the Civil Code, or subdivision (b) of Section 5328 of
26 the Welfare and Institutions Code.*

27 (4) When the defendant is committed to a treatment facility
28 pursuant to clause (i) of subparagraph (B) of paragraph (1) or the
29 court makes the findings specified in clause ~~(ii) or~~ (iii) or (iv) of
30 subparagraph (B) of paragraph (1) to assign the defendant to a
31 treatment facility other than a State Department of State Hospitals
32 facility or other secure treatment facility, the court shall order that
33 notice be given to the appropriate law enforcement agency or
34 agencies having local jurisdiction at the placement facility of a
35 finding of mental incompetence pursuant to this chapter arising
36 out of a charge of a Section 290 offense.

37 (5) When directing that the defendant be confined in a State
38 Department of State Hospitals facility pursuant to this subdivision,
39 the court shall commit the defendant to the State Department of
40 State Hospitals.

1 (6) (A) If the defendant is committed or transferred to the State
2 Department of State Hospitals pursuant to this section, the court
3 may, upon receiving the written recommendation of the medical
4 director of the State Department of State Hospitals facility and the
5 community program director that the defendant be transferred to
6 a public or private treatment facility approved by the community
7 program director, order the defendant transferred to that facility.
8 If the defendant is committed or transferred to a public or private
9 treatment facility approved by the community program director,
10 the court may, upon receiving the written recommendation of the
11 community program director, transfer the defendant to the State
12 Department of State Hospitals or to another public or private
13 treatment facility approved by the community program director.
14 In the event of dismissal of the criminal charges before the
15 defendant recovers competence, the person shall be subject to the
16 applicable provisions of the Lanterman-Petris-Short Act (Part 1
17 commencing with Section 5000) of Division 5 of the Welfare and
18 Institutions Code). If either the defendant or the prosecutor chooses
19 to contest either kind of order of transfer, a petition may be filed
20 in the court for a hearing, which shall be held if the court
21 determines that sufficient grounds exist. At the hearing, the
22 prosecuting attorney or the defendant may present evidence bearing
23 on the order of transfer. The court shall use the same standards as
24 are used in conducting probation revocation hearings pursuant to
25 Section 1203.2.

26 Prior to making an order for transfer under this section, the court
27 shall notify the defendant, the attorney of record for the defendant,
28 the prosecuting attorney, and the community program director or
29 a designee.

30 (B) If the defendant is initially committed to a State Department
31 of State Hospitals facility or secure treatment facility pursuant to
32 clause ~~(ii)~~ or (iii) or (iv) of subparagraph (B) of paragraph (1) and
33 is subsequently transferred to any other facility, copies of the
34 documents specified in paragraph (3) shall be electronically
35 transferred or taken with the defendant to each subsequent facility
36 to which the defendant is transferred. The transferring facility shall
37 also notify the appropriate law enforcement agency or agencies
38 having local jurisdiction at the site of the new facility that the
39 defendant is a person subject to clause ~~(ii)~~ or (iii) or (iv) of
40 subparagraph (B) of paragraph (1).

1 (7) (A) An order by the court authorizing involuntary
2 medication of the defendant shall be valid for no more than one
3 year. The court shall review the order at the time of the review of
4 the initial report and the six-month progress reports pursuant to
5 paragraph (1) of subdivision (b) to determine if the grounds for
6 the authorization remain. In the review, the court shall consider
7 the reports of the treating psychiatrist or psychiatrists and the
8 defendant's patients' rights advocate or attorney. The court may
9 require testimony from the treating psychiatrist and the patients'
10 rights advocate or attorney, if necessary. The court may continue
11 the order authorizing involuntary medication for up to another six
12 months, or vacate the order, or make any other appropriate order.

13 (B) Within 60 days before the expiration of the one-year
14 involuntary medication order, the district attorney, county counsel,
15 or representative of any facility where a defendant found
16 incompetent to stand trial is committed may petition the committing
17 court for a renewal, subject to the same conditions and
18 requirements as in subparagraph (A). The petition shall include
19 the basis for involuntary medication set forth in clause (i) of
20 subparagraph (B) of paragraph (2). Notice of the petition shall be
21 provided to the defendant, the defendant's attorney, and the district
22 attorney. The court shall hear and determine whether the defendant
23 continues to meet the criteria set forth in clause (i) of subparagraph
24 (B) of paragraph (2). The hearing on a petition to renew an order
25 for involuntary medication shall be conducted prior to the
26 expiration of the current order.

27 (8) For purposes of subparagraph (D) of paragraph (2) and
28 paragraph (7), if the treating psychiatrist determines that there is
29 a need, based on preserving their rapport with the defendant or
30 preventing harm, the treating psychiatrist may request that the
31 facility medical director designate another psychiatrist to act in
32 the place of the treating psychiatrist. If the medical director of the
33 facility designates another psychiatrist to act pursuant to this
34 paragraph, the treating psychiatrist shall brief the acting psychiatrist
35 of the relevant facts of the case and the acting psychiatrist shall
36 examine the defendant prior to the hearing.

37 (b) (1) Within 90 days after a commitment made pursuant to
38 subdivision (a), the medical director of the State Department of
39 State Hospitals facility or other treatment facility to which the
40 defendant is confined shall make a written report to the court and

1 the community program director for the county or region of
2 commitment, or a designee, concerning the defendant's progress
3 toward recovery of mental competence and whether the
4 administration of antipsychotic medication remains necessary.

5 If the defendant is in county custody, the county jail shall provide
6 access to the defendant for purposes of the State Department of
7 State Hospitals conducting an evaluation of the defendant pursuant
8 to Section 4335.2 of the Welfare and Institutions Code. Based
9 upon this evaluation, the State Department of State Hospitals may
10 make a written report to the court within 90 days of a commitment
11 made pursuant to subdivision (a) concerning the defendant's
12 progress toward recovery of mental incompetence and whether
13 the administration of antipsychotic medication is necessary. If the
14 defendant remains in county custody after the initial 90-day report,
15 the State Department of State Hospitals may conduct an evaluation
16 of the defendant pursuant to Section 4335.2 of the Welfare and
17 Institutions Code and make a written report to the court concerning
18 the defendant's progress toward recovery of mental incompetence
19 and whether the administration of antipsychotic medication is
20 necessary.

21 If the defendant is on outpatient status, the outpatient treatment
22 staff shall make a written report to the community program director
23 concerning the defendant's progress toward recovery of mental
24 competence. Within 90 days of placement on outpatient status, the
25 community program director shall report to the court on this matter.
26 If the defendant has not recovered mental competence, but the
27 report discloses a substantial likelihood that the defendant will
28 regain mental competence in the foreseeable future, the defendant
29 shall remain in the State Department of State Hospitals facility or
30 other treatment facility or on outpatient status. Thereafter, at
31 six-month intervals or until the defendant becomes mentally
32 competent, if the defendant is confined in a treatment facility, the
33 medical director of the State Department of State Hospitals facility
34 or person in charge of the facility shall report, in writing, to the
35 court and the community program director or a designee regarding
36 the defendant's progress toward recovery of mental competence
37 and whether the administration of antipsychotic medication remains
38 necessary. If the defendant is on outpatient status, after the initial
39 90-day report, the outpatient treatment staff shall report to the
40 community program director on the defendant's progress toward

1 recovery, and the community program director shall report to the
2 court on this matter at six-month intervals. A copy of these reports
3 shall be provided to the prosecutor and defense counsel by the
4 court.

5 (A) If the report indicates that there is no substantial likelihood
6 that the defendant will regain mental competence in the foreseeable
7 future, custody of the defendant shall be transferred without delay
8 to the committing county and shall remain with the county until
9 further order of the court. The defendant shall be returned to the
10 court for proceedings pursuant to paragraph (2) of subdivision (c)
11 no later than 10 days following receipt of the report. The court
12 shall not order the defendant returned to the custody of the State
13 Department of State Hospitals under the same commitment. The
14 court shall transmit a copy of its order to the community program
15 director or a designee.

16 (B) If the report indicates that there is no substantial likelihood
17 that the defendant will regain mental competence in the foreseeable
18 future, the medical director of the State Department of State
19 Hospitals facility or other treatment facility to which the defendant
20 is confined shall do both of the following:

21 (i) Promptly notify and provide a copy of the report to the
22 defense counsel and the district attorney.

23 (ii) Provide a separate notification, in compliance with
24 applicable privacy laws, to the committing county's sheriff that
25 immediate transportation will be needed for the defendant pursuant
26 to subparagraph (A).

27 (C) If a county does not take custody of a defendant committed
28 to the State Department of State Hospitals within 10 calendar days
29 following notification made pursuant to clause (ii) of subparagraph
30 (B), the county shall be charged the daily rate for a state hospital
31 bed, as established by the State Department of State Hospitals.

32 (2) The reports made pursuant to paragraph (1) concerning the
33 defendant's progress toward regaining competency shall also
34 consider the issue of involuntary medication. Each report shall
35 include, but not be limited to, all of the following:

36 (A) Whether or not the defendant has the capacity to make
37 decisions concerning antipsychotic medication.

38 (B) If the defendant lacks capacity to make decisions concerning
39 antipsychotic medication, whether the defendant risks serious harm

1 to their physical or mental health if not treated with antipsychotic
2 medication.

3 (C) Whether or not the defendant presents a danger to others if
4 the defendant is not treated with antipsychotic medication.

5 (D) Whether the defendant has a mental disorder for which
6 medications are the only effective treatment.

7 (E) Whether there are any side effects from the medication
8 currently being experienced by the defendant that would interfere
9 with the defendant's ability to collaborate with counsel.

10 (F) Whether there are any effective alternatives to medication.

11 (G) How quickly the medication is likely to bring the defendant
12 to competency.

13 (H) Whether the treatment plan includes methods other than
14 medication to restore the defendant to competency.

15 (I) A statement, if applicable, that no medication is likely to
16 restore the defendant to competency.

17 (3) After reviewing the reports, the court shall determine if
18 grounds for the involuntary administration of antipsychotic
19 medication exist, whether or not an order was issued at the time
20 of commitment, and shall do one of the following:

21 (A) If the original grounds for involuntary medication still exist,
22 any order authorizing the treating facility to involuntarily
23 administer antipsychotic medication to the defendant shall remain
24 in effect.

25 (B) If the original grounds for involuntary medication no longer
26 exist, and there is no other basis for involuntary administration of
27 antipsychotic medication, any order for the involuntary
28 administration of antipsychotic medication shall be vacated.

29 (C) If the original grounds for involuntary medication no longer
30 exist, and the report states that there is another basis for involuntary
31 administration of antipsychotic medication, the court shall
32 determine whether to vacate the order or issue a new order for the
33 involuntary administration of antipsychotic medication. The court
34 shall consider the opinions in reports submitted pursuant to
35 paragraph (1) of subdivision (b), including any opinions rendered
36 pursuant to Section 4335.2 of the Welfare and Institutions Code.
37 The court may, upon a showing of good cause, set a hearing within
38 21 days to determine whether the order for the involuntary
39 administration of antipsychotic medication shall be vacated or
40 whether a new order for the involuntary administration of

1 antipsychotic medication shall be issued. The hearing shall proceed
2 as set forth in subparagraph (B) of paragraph (2) of subdivision
3 (a). The court shall require witness testimony to occur remotely,
4 including clinical testimony pursuant to subdivision (d) of Section
5 4335.2 of the Welfare and Institutions Code. In-person witness
6 testimony shall only be allowed upon a court's finding of good
7 cause.

8 (D) If the report states a basis for involuntary administration of
9 antipsychotic medication and the court did not issue such order at
10 the time of commitment, the court shall determine whether to issue
11 an order for the involuntary administration of antipsychotic
12 medication. The court shall consider the opinions in reports
13 submitted pursuant to paragraph (1) of subdivision (b), including
14 any opinions rendered pursuant to Section 4335.2 of the Welfare
15 and Institutions Code. The court may, upon a finding of good
16 cause, set a hearing within 21 days to determine whether an order
17 for the involuntary administration of antipsychotic medication
18 shall be issued. The hearing shall proceed as set forth in
19 subparagraph (B) of paragraph (2) of subdivision (a). The court
20 shall require witness testimony to occur remotely, including clinical
21 testimony pursuant to subdivision (d) of Section 4335.2 of the
22 Welfare and Institutions Code. In-person witness testimony shall
23 only be allowed upon a court's finding of good cause.

24 *(E) This paragraph also applies to recommendations submitted*
25 *pursuant to subdivision (e) of Section 1372, when a*
26 *recommendation is included as to whether an order for the*
27 *involuntary administration of antipsychotic medications should*
28 *be extended or issued.*

29 (4) If it is determined by the court that treatment for the
30 defendant's mental impairment is not being conducted, the
31 defendant shall be returned to the committing court, and, if the
32 defendant is not in county custody, returned to the custody of the
33 county. The court shall transmit a copy of its order to the
34 community program director or a designee.

35 (5) At each review by the court specified in this subdivision,
36 the court shall determine if the security level of housing and
37 treatment is appropriate and may make an order in accordance
38 with its determination. If the court determines that the defendant
39 shall continue to be treated in the State Department of State
40 Hospitals facility or on an outpatient basis, the court shall

1 determine issues concerning administration of antipsychotic
2 medication, as set forth in subparagraph (B) of paragraph (2) of
3 subdivision (a).

4 (c) (1) At the end of two years from the date of commitment
5 or a period of commitment equal to the maximum term of
6 imprisonment provided by law for the most serious offense charged
7 in the information, indictment, or complaint, or the maximum term
8 of imprisonment provided by law for a violation of probation or
9 mandatory supervision, whichever is shorter, but no later than 90
10 days prior to the expiration of the defendant's term of commitment,
11 a defendant who has not recovered mental competence shall be
12 returned to the committing court, and custody of the defendant
13 shall be transferred without delay to the committing county and
14 shall remain with the county until further order of the court. The
15 court shall not order the defendant returned to the custody of the
16 State Department of State Hospitals under the same commitment.
17 The court shall notify the community program director or a
18 designee of the return and of any resulting court orders.

19 (2) (A) The medical director of the State Department of State
20 Hospitals facility or other treatment facility to which the defendant
21 is confined shall provide notification, in compliance with applicable
22 privacy laws, to the committing county's sheriff that immediate
23 transportation will be needed for the defendant pursuant to
24 paragraph (1).

25 (B) If a county does not take custody of a defendant committed
26 to the State Department of State Hospitals within 10 calendar days
27 following notification pursuant to subparagraph (A), the county
28 shall be charged the daily rate for a state hospital bed, as
29 established by the State Department of State Hospitals.

30 (3) Whenever a defendant is returned to the court pursuant to
31 paragraph (1) or (4) of subdivision (b) or paragraph (1) of this
32 subdivision and it appears to the court that the defendant is gravely
33 disabled, as defined in subparagraph (A) or (B) of paragraph (1)
34 of subdivision (h) of Section 5008 of the Welfare and Institutions
35 Code, the court shall order the conservatorship investigator of the
36 county of commitment of the defendant to initiate conservatorship
37 proceedings for the defendant pursuant to Chapter 3 (commencing
38 with Section 5350) of Part 1 of Division 5 of the Welfare and
39 Institutions Code. Hearings required in the conservatorship
40 proceedings shall be held in the superior court in the county that

1 ordered the commitment. The court shall transmit a copy of the
2 order directing initiation of conservatorship proceedings to the
3 community program director or a designee, the sheriff and the
4 district attorney of the county in which criminal charges are
5 pending, and the defendant’s counsel of record. The court shall
6 notify the community program director or a designee, the sheriff
7 and district attorney of the county in which criminal charges are
8 pending, and the defendant’s counsel of record of the outcome of
9 the conservatorship proceedings.

10 (4) If a change in placement is proposed for a defendant who
11 is committed pursuant to subparagraph (A) or (B) of paragraph
12 (1) of subdivision (h) of Section 5008 of the Welfare and
13 Institutions Code, the court shall provide notice and an opportunity
14 to be heard with respect to the proposed placement of the defendant
15 to the sheriff and the district attorney of the county in which the
16 criminal charges or revocation proceedings are pending.

17 (5) If the defendant is confined in a treatment facility, a copy
18 of any report to the committing court regarding the defendant’s
19 progress toward recovery of mental competence shall be provided
20 by the committing court to the prosecutor and to the defense
21 counsel.

22 (d) With the exception of proceedings alleging a violation of
23 mandatory supervision, the criminal action remains subject to
24 dismissal pursuant to Section 1385. If the criminal action is
25 dismissed, the court shall transmit a copy of the order of dismissal
26 to the community program director or a designee. In a proceeding
27 alleging a violation of mandatory supervision, if the person is not
28 placed under a conservatorship as described in paragraph (3) of
29 subdivision (c), or if a conservatorship is terminated, the court
30 shall reinstate mandatory supervision and may modify the terms
31 and conditions of supervision to include appropriate mental health
32 treatment or refer the matter to a local mental health court, reentry
33 court, or other collaborative justice court available for improving
34 the mental health of the defendant.

35 (e) If the criminal action against the defendant is dismissed, the
36 defendant shall be released from commitment ordered under this
37 section, but without prejudice to the initiation of proceedings that
38 may be appropriate under the Lanterman-Petris-Short Act (Part 1
39 (commencing with Section 5000) of Division 5 of the Welfare and
40 Institutions Code).

1 (f) As used in this chapter, “community program director” means
2 the person, agency, or entity designated by the State Department
3 of State Hospitals pursuant to Section 1605 of this code and Section
4 4360 of the Welfare and Institutions Code.

5 (g) For the purpose of this section, “secure treatment facility”
6 does not include, except for State Department of State Hospitals
7 facilities, state developmental centers, and correctional treatment
8 facilities, any facility licensed pursuant to Chapter 2 (commencing
9 with Section 1250) of, Chapter 3 (commencing with Section 1500)
10 of, or Chapter 3.2 (commencing with Section 1569) of, Division
11 2 of the Health and Safety Code, or any community board and care
12 facility.

13 (h) This section does not preclude a defendant from filing a
14 petition for habeas corpus to challenge the continuing validity of
15 an order authorizing a treatment facility or outpatient program to
16 involuntarily administer antipsychotic medication to a person being
17 treated as incompetent to stand trial.

18 *SEC. 32. Section 1372 of the Penal Code is amended to read:*

19 1372. (a) (1) If the medical director of a state hospital, a
20 person designated by the State Department of State Hospitals at
21 an entity contracted by the department to provide services to a
22 defendant prior to placement in a treatment program or other
23 facility to which the defendant is committed, or the community
24 program director, county mental health director, or regional center
25 director providing outpatient services, determines that the defendant
26 has regained mental competence, the director or designee shall
27 immediately certify that fact to the court by filing a certificate of
28 restoration with the court by certified mail, return receipt requested,
29 or by confidential electronic transmission. This shall include any
30 certificate of restoration filed by the State Department of State
31 Hospitals based on an evaluation conducted pursuant to Section
32 4335.2 of the Welfare and Institutions Code. For purposes of this
33 section, the date of filing shall be the date on the return receipt.

34 (2) The court’s order committing an individual to a State
35 Department of State Hospitals facility or other treatment facility
36 pursuant to Section 1370 shall include direction that the sheriff
37 shall redeliver the patient to the court without any further order
38 from the court upon receiving from the state hospital or treatment
39 facility a copy of the certificate of restoration.

1 (3) The defendant shall be returned to the committing court in
2 the following manner, except that a defendant in county custody
3 that the State Department of State Hospitals has evaluated pursuant
4 to Section 4335.2 of the Welfare and Institutions Code and filed
5 a certificate of restoration with the court shall remain in county
6 custody:

7 (A) A patient who remains confined in a state hospital or other
8 treatment facility shall be redelivered to the sheriff of the county
9 from which the patient was committed. The sheriff shall
10 immediately return the person from the state hospital or other
11 treatment facility to the court for further proceedings.

12 (B) The patient who is on outpatient status shall be returned by
13 the sheriff to court through arrangements made by the outpatient
14 treatment supervisor.

15 (C) In all cases, the patient shall be returned to the committing
16 court no later than 10 days following the filing of a certificate of
17 restoration. The state shall only pay for 10 ~~hospital~~ *calendar* days
18 for patients *who remain in a facility described in Section 4100 of*
19 *the Welfare and Institutions Code* following the filing of a
20 certificate of restoration of competency. The State Department of
21 State Hospitals shall report to the fiscal and appropriate policy
22 committees of the Legislature on an annual basis in February, on
23 the number of days that exceed the 10-day limit prescribed in this
24 subparagraph. This report shall include, but not be limited to, a
25 data sheet that itemizes by county the number of days that exceed
26 this 10-day limit during the preceding year.

27 (b) If the defendant becomes mentally competent after a
28 conservatorship has been established pursuant to the applicable
29 provisions of the Lanterman-Petris-Short Act, Part 1 (commencing
30 with Section 5000) of Division 5 of the Welfare and Institutions
31 Code, and Section 1370, the conservator shall certify that fact to
32 the sheriff and district attorney of the county in which the
33 defendant's case is pending, defendant's attorney of record, and
34 the committing court.

35 (c) (1) When a defendant is returned to court with a
36 certification that competence has been regained, including a
37 certification of restoration provided pursuant to Section 4335.2 of
38 the Welfare and Institutions Code, the court shall notify either the
39 community program director, the county mental health director,
40 the State Department of State Hospitals, or the regional center

1 director and the Director of Developmental Services, as
2 appropriate, of the date of any hearing on the defendant's
3 competence and whether or not the defendant was found by the
4 court to have recovered competence.

5 (2) If the court rejects a certificate of restoration, the court shall
6 base its rejection on a written report of an evaluation, conducted
7 by a licensed psychologist or psychiatrist, that the defendant is not
8 competent. The evaluation shall be conducted after the certificate
9 of restoration is filed with the committing court and in compliance
10 with Section 1369. A copy of the written report shall be provided
11 to the department pursuant to paragraph (3) of subdivision (a) of
12 Section 1370. The court shall also provide a copy of the court order
13 or minute order rejecting the certification of restoration to the
14 department, pursuant to clause (ii) of subparagraph (C) of
15 paragraph (3) of subdivision (a) of Section 1370, including any
16 minute orders continuing the hearing for the court's determination.

17 (d) If the committing court approves the certificate of restoration
18 to competence as to a person in custody, the court shall notify the
19 State Department of State Hospitals by providing the State
20 Department of State Hospitals with a copy of the court order or
21 minute order approving the certificate of restoration to competence.
22 The court shall hold a hearing to determine whether the person is
23 entitled to be admitted to bail or released on own recognizance
24 status pending conclusion of the proceedings. If the superior court
25 approves the certificate of restoration to competence regarding a
26 person on outpatient status, unless it appears that the person has
27 refused to come to court, that person shall remain released either
28 on own recognizance status, or, in the case of a developmentally
29 disabled person, either on the defendant's promise or on the
30 promise of a responsible adult to secure the person's appearance
31 in court for further proceedings. If the person has refused to come
32 to court, the court shall set bail and may place the person in custody
33 until bail is posted.

34 (e) (1) A defendant subject to either subdivision (a) or (b) who
35 is not admitted to bail or released under subdivision (d) may, at
36 the discretion of the court, *and only upon the recommendation of*
37 ~~the director of the facility where the defendant is receiving~~
38 ~~treatment~~, *person or entity that issued the certification of*
39 *restoration to competence*, be returned to the hospital or facility
40 of their original commitment or other appropriate secure facility

1 approved by the community program director, the county mental
2 health director, or the regional center director. *If the*
3 *recommendation was submitted by the State Department of State*
4 *Hospitals, the defendant shall be placed at a facility described in*
5 *Section 4100 of the Welfare and Institutions Code at the discretion*
6 *of, and as directed by, the department.* The recommendation
7 submitted to the court shall be based on the opinion that the person
8 will need continued treatment in a hospital or treatment facility in
9 order to maintain competence to stand trial or that placing the
10 person in a jail environment would create a substantial risk that
11 the person would again become incompetent to stand trial before
12 criminal proceedings could be ~~resumed~~. *resumed or completed.*

13 (2) Any return to treatment pursuant to this subdivision shall
14 be subject to the following procedures:

15 (A) *The recommendation described in paragraph (1) shall*
16 *include a recommendation as to whether an order for the*
17 *involuntary administration of antipsychotic medications should*
18 *be extended or issued. The court shall review the recommendation*
19 *in accordance with the procedure outlined in paragraph (3) of*
20 *subdivision (b) of Section 1370, and determine if the grounds for*
21 *authorization apply. If an order authorizing the involuntary*
22 *administration of antipsychotic medication already exists, the court*
23 *may continue the order for no more than one year or may vacate*
24 *the order. If an order does not exist, the court may issue an order*
25 *for no more than one year. The court shall provide copies of the*
26 *reports of the treating psychiatrist or psychiatrists and the*
27 *defendant's patients' rights advocate or attorney, as applicable,*
28 *to both the prosecutor and defense counsel.*

29 (B) *If an order for the involuntary administration of*
30 *antipsychotic medication is not authorized by the court pursuant*
31 *to subparagraph (A), the defendant's treating psychiatrist, or*
32 *medical director designee, may pursue an order in the manner*
33 *outlined in subparagraphs (C) and (D) of paragraph (2) of*
34 *subdivision (a) of Section 1370.*

35 (C) *If an order for the involuntary administration of*
36 *antipsychotic medication is not renewed by the court pursuant to*
37 *subparagraph (A), the district attorney, county counsel, or*
38 *representative of any facility where a defendant is placed pursuant*
39 *to paragraph (1) may petition the committing court for a renewal*
40 *within 60 days before the expiration of the one-year involuntary*

1 medication order. The petition shall include the basis for
2 involuntary medication set forth in clause (i) of subparagraph (B)
3 of paragraph (2) of subdivision (a) of Section 1370. Notice of the
4 petition shall be provided to the defendant, the defendant's
5 attorney, and the district attorney. The court shall hear and
6 determine whether the defendant continues to meet the criteria set
7 forth in clause (i) of subparagraph (B) of paragraph (2) of
8 subdivision (a) of Section 1370. The court may renew the order
9 for no more than one year. The court may review the petition and
10 renew the order based on the petition. If the court has a hearing
11 on the petition to renew an order for involuntary medication, the
12 hearing shall be conducted prior to the expiration of the current
13 order. The court may, for a period not to exceed 14 days, extend
14 the involuntary medication order and continue the hearing
15 pursuant to stipulation between the parties or upon a finding of
16 good cause. In determining good cause, the court may review the
17 petition filed with the court, and any additional testimony needed
18 by the court, to determine if it is appropriate to continue medication
19 beyond the expiration date and for a period of up to 14 days.

20 (D) Upon the determination by the medical director or designee
21 of the State Department of State Hospitals facility or other
22 treatment facility to which the defendant is confined that the
23 defendant no longer satisfies the criteria for continued treatment
24 under this subdivision, the medical director or designee shall
25 immediately certify that fact to the court by filing a written report
26 containing those findings. The filing of the report shall
27 automatically trigger the return of the defendant to county custody
28 in the manner described in paragraph (3) of subdivision (a).

29 (f) Notwithstanding subdivision (e), if a defendant is returned
30 by the court to a hospital or other facility for the purpose of
31 maintaining competency to stand trial and that defendant is already
32 under civil commitment to that hospital or facility from another
33 county pursuant to the Lanterman-Petris-Short Act (Part 1
34 commencing with Section 5000) of Division 5 of the Welfare and
35 Institutions Code) or as a developmentally disabled person
36 committed pursuant to Article 2 (commencing with Section 6500)
37 of Chapter 2 of Part 2 of Division 6 of the Welfare and Institutions
38 Code, the costs of housing and treating the defendant in that facility
39 following return pursuant to subdivision (e) shall be the
40 responsibility of the original county of civil commitment.

1 *SEC. 33. Section 30130.59 of the Revenue and Taxation Code*
2 *is repealed.*

3 ~~30130.59. Notwithstanding Section 13340 of the Government~~
4 ~~Code, if the board, pursuant to subdivision (h) of Section 30130.57,~~
5 ~~reduces the allocation to the State Department of Public Health~~
6 ~~state dental program due to a reduction in revenues, there is hereby~~
7 ~~continuously appropriated from the state General Fund an amount~~
8 ~~equivalent to the required reduction so that the total funding for~~
9 ~~the state dental program is maintained at thirty million dollars~~
10 ~~(\$30,000,000) annually.~~

11 *SEC. 34. Section 14902 of the Vehicle Code is amended to*
12 *read:*

13 14902. (a) Except as otherwise provided in subdivisions (b),
14 (c), (d), (g), and (h) of this section, subdivision (c) of Section
15 13002, and subdivision (c) of Section 14900, upon an application
16 for an identification card a fee of ~~twenty dollars (\$20), and on and~~
17 ~~after January 1, 2010, a fee of twenty-six dollars (\$26), (\$26)~~ shall
18 be paid to the department.

19 (b) An original or replacement senior citizen identification card
20 issued pursuant to subdivision (b) of Section 13000 shall be issued
21 free of charge.

22 (c) The fee for an original or replacement identification card
23 issued to a person who has been determined to have a current
24 income level that meets the eligibility requirements for assistance
25 programs under Chapter 2 (commencing with Section 11200) or
26 Chapter 3 (commencing with Section 12000) of Part 3 of, or Part
27 5 (commencing with Section 17000) of, or Article 9 (commencing
28 with Section 18900) of Chapter 10 of Part 6 of, or Chapter 10.1
29 (commencing with Section 18930) or Chapter 10.3 (commencing
30 with Section 18937) of Part 6 of, Division 9 of the Welfare and
31 Institutions Code shall be six dollars (\$6). The determination of
32 eligibility under this subdivision shall be made by a governmental
33 or nonprofit entity, which shall be subject to regulations adopted
34 by the department.

35 (d) A fee shall not be charged for an original or replacement
36 identification card issued to any person who can verify their status
37 as a homeless person or homeless child or youth. A homeless
38 services provider that has knowledge of the person's housing status
39 may verify the person's status for purposes of this subdivision. A
40 determination of eligibility pursuant to this subdivision shall be

1 subject to regulations adopted by the department. A person
2 applying for an identification card under this subdivision shall not
3 be charged a fee for verification of their eligibility.

4 (e) All fees received pursuant to this section shall be deposited
5 in the Motor Vehicle Account.

6 (f) For purposes of this section, the following definitions apply:

7 (1) A “homeless child or youth” has the same meaning as the
8 definition of “homeless children and youths” as set forth in the
9 federal McKinney-Vento Homeless Assistance Act (42 U.S.C.
10 Sec. 11301 et seq.).

11 (2) A “homeless person” has the same meaning as the definition
12 set forth in the federal McKinney-Vento Homeless Assistance Act
13 (42 U.S.C. Sec. 11301 et seq.).

14 (3) A “homeless services provider” includes:

15 (A) A governmental or nonprofit agency receiving federal, state,
16 or county or municipal funding to provide services to a “homeless
17 person” or “homeless child or youth,” or that is otherwise
18 sanctioned to provide those services by a local homeless continuum
19 of care organization.

20 (B) An attorney licensed to practice law in this state.

21 (C) A local educational agency liaison for homeless children
22 and youth designated as such pursuant to Section 11432 (g)(1)(J)(ii)
23 of Title 42 of the United States Code, or a school social worker.

24 (D) A human services provider or public social services provider
25 funded by the State of California to provide homeless children or
26 youth services, health services, mental or behavioral health
27 services, substance use disorder services, or public assistance or
28 employment services.

29 (E) A law enforcement officer designated as a liaison to the
30 homeless population by a local police department or sheriff’s
31 department within the state.

32 (F) Any other homeless services provider that is qualified to
33 verify an individual’s housing status, as determined by the
34 department.

35 (g) The fee for a replacement identification card issued to an
36 eligible inmate upon release from a federal correctional facility or
37 a county jail facility is eight dollars (\$8). For purposes of this
38 subdivision, “eligible inmate” means an inmate who meets all of
39 the following requirements:

1 (1) The inmate previously held a California driver’s license or
2 identification card.

3 (2) The inmate has a usable photo on file with the department
4 that is not more than 10 years old.

5 (3) The inmate has no outstanding fees due for a prior California
6 identification card.

7 (4) The inmate has provided, and the department has verified,
8 their true full name, date of birth, social security number, and legal
9 presence in the United States, or, upon implementation of
10 paragraph (2) of subdivision (a) of Section 12801.9, if the inmate
11 is unable to submit satisfactory proof that their presence in the
12 United States is authorized under federal law, the inmate has
13 provided proof of their identity pursuant to Section 12801.9.

14 (5) The inmate currently resides in a federal correctional facility
15 or a county jail facility.

16 (6) The inmate has provided the department, upon application,
17 a verification of their eligibility under this subdivision that meets
18 all of the following requirements:

19 (A) Be on federal correctional facility letterhead or county
20 sheriff letterhead.

21 (B) Be typed or computer generated.

22 (C) Contain the inmate’s name.

23 (D) Contain the inmate’s date of birth.

24 (E) Contain the original signature of an official from the federal
25 correctional facility or county sheriff’s office.

26 (F) Be dated within 90 days of the date of application.

27 (h) The fee for an original or replacement identification card
28 issued to an eligible inmate upon release from a state correctional
29 facility is eight dollars (\$8). For purposes of this subdivision,
30 “eligible inmate” has the same meaning as that term is defined
31 under subdivision (b) of Section 3007.05 of the Penal Code, and
32 meets both of the following requirements:

33 (1) The inmate currently resides in a facility housing inmates
34 under the control of the Department of Corrections and
35 Rehabilitation.

36 (2) The inmate has provided the department, upon application,
37 a verification of their eligibility under this subdivision that meets
38 the requirements described under subparagraphs (A) to (D),
39 inclusive, and (F) of paragraph (6) of subdivision (g) and contains
40 the signature of an official from the state facility.

1 (i) ~~(I)~~ The fee for ~~a~~ *an original or* replacement identification
 2 card issued to an eligible patient treated in a facility of the State
 3 Department of State Hospitals is eight dollars (\$8). For purposes
 4 of this subdivision, “eligible patient” means a patient who *is*
 5 *currently housed in a facility described in Section 4100 of the*
 6 *Welfare and Institutions Code, is preparing to be discharged*
 7 *unconditionally or through a conditional release program, and*
 8 *who meets all either of the following sets of requirements:*

9 ~~(1)~~

10 (A) The patient *has* previously held a California driver’s license
 11 or identification ~~card~~. *card and all of the following requirements*
 12 *are met:*

13 ~~(2)~~

14 (i) The patient has a usable photo on file with the department
 15 that is not more than 10 years ~~old~~. *old or has a new usable photo*
 16 *taken.*

17 ~~(3) The patient has no outstanding fees due for a prior California~~
 18 ~~identification card.~~

19 ~~(4)~~

20 (ii) The patient has provided, and the department has verified,
 21 their true full name, date of birth, social security number,
 22 *California residence*, and legal presence in the United States, or,
 23 upon implementation of paragraph (2) of subdivision (a) of Section
 24 12801.9, if the patient is unable to submit satisfactory proof that
 25 their presence in the United States is authorized under federal law,
 26 the patient has provided proof of their identity pursuant to Section
 27 12801.9.

28 ~~(5) The patient is currently preparing to be unconditionally~~
 29 ~~discharged from a facility of the State Department of State~~
 30 ~~Hospitals, or through a conditional release program.~~

31 ~~(6)~~

32 (iii) The patient has provided the department, upon application,
 33 a verification of their eligibility under this subdivision that meets
 34 all of the following requirements:

35 ~~(A)~~

36 (I) Be on State Department of State Hospitals letterhead.

37 ~~(B)~~

38 (II) Be typed or computer generated.

39 ~~(C)~~

40 (III) Contain the patient’s name.

- 1 ~~(D)~~
2 (IV) Contain the patient’s date of birth.
3 ~~(E)~~
4 (V) Contain the original signature of an official from the State
5 Department of State Hospitals.
6 ~~(F)~~
7 (VI) Be dated within 90 days of the date of application.
8 (B) *The patient has not previously held a California driver’s*
9 *license or identification card and all of the following requirements*
10 *are met:*
11 (i) *The patient has verified and signed under penalty of perjury*
12 *a completed application for an identification card.*
13 (ii) *The patient has a usable photo taken.*
14 (iii) *The patient provides a legible print of the thumb or finger.*
15 (iv) *The patient has provided acceptable proof of the information*
16 *described in clause (ii) of subparagraph (A), subject to verification*
17 *by the department.*
18 (v) *The patient has provided verification of eligibility as*
19 *described in clause (iii) of subparagraph (A).*
20 (2) *The State Department of State Hospitals shall reimburse the*
21 *Department of Motor Vehicles for any actual costs incurred in*
22 *providing assistance pursuant to this paragraph.*
23 SEC. 35. *Section 4361 of the Welfare and Institutions Code is*
24 *amended to read:*
25 4361. (a) As used in this section, “department” means the State
26 Department of State Hospitals.
27 (b) The purpose of this chapter is to, subject to appropriation
28 by the Legislature, promote the diversion of individuals with
29 serious mental disorders as prescribed in Chapter 2.8A
30 (commencing with Section 1001.35) of Title 6 of Part 2 of the
31 Penal Code, and to assist counties in providing diversion for
32 individuals with serious mental illnesses who have been found
33 incompetent to stand trial and committed to the department for
34 restoration of competency. In implementing this chapter, the
35 department shall consider local discretion and flexibility in
36 diversion activities that meet the community’s needs and provide
37 for the safe and effective treatment of individuals with serious
38 mental disorders across a continuum of care.
39 (c) (1) Subject to appropriation by the Legislature, the
40 department may solicit proposals from, and may contract with, a

1 county to help fund the development or expansion of pretrial
2 diversion described in Chapter 2.8A (commencing with Section
3 1001.35) of Title 6 of Part 2 of the Penal Code, for the population
4 described in subdivision (b) and that meets all of the following
5 criteria:

6 (A) Participants are individuals diagnosed with a mental disorder
7 as identified in the most recent edition of the Diagnostic and
8 Statistical Manual of Mental Disorders, including, but not limited
9 to, bipolar disorder, schizophrenia, and schizoaffective disorder,
10 but excluding a primary diagnosis of antisocial personality disorder,
11 borderline personality disorder, and pedophilia, and who are
12 presenting non-substance-induced psychotic symptoms, who have
13 been found incompetent to stand trial pursuant to clause (iv) of
14 subparagraph (B) of paragraph (1) of subdivision (a) of Section
15 1370 of the Penal Code.

16 (B) There is a significant relationship between the individual's
17 serious mental disorder and the charged offense, or between the
18 individual's conditions of homelessness and the charged offense.

19 (C) The individual does not pose an unreasonable risk of danger
20 to public safety, as defined in Section 1170.18 of the Penal Code,
21 if treated in the community.

22 (2) A county submitting a proposal for funding under this
23 chapter shall designate a lead entity to apply for the funds. This
24 lead entity shall show in its proposal that it has support from other
25 county entities or other relevant entities, including courts, that are
26 necessary to provide successful diversion of individuals under the
27 contract.

28 (d) When evaluating proposals from the county, the department,
29 in consultation with the Council on Criminal Justice and Behavioral
30 Health within the Department of Corrections and Rehabilitation,
31 shall prioritize proposals that demonstrate all of the following:

32 (1) Provision of clinically appropriate or evidence-based mental
33 health treatment and wraparound services across a continuum of
34 care, as appropriate, to meet the individual needs of the diversion
35 participant. For purposes of this section, "wraparound services"
36 means services provided in addition to the mental health treatment
37 necessary to meet the individual's needs for successfully managing
38 the individual's mental health symptoms and to successfully live
39 in the community. Wraparound services provided by the diversion
40 program shall include appropriate housing, intensive case

1 management, and substance use disorder treatment, and may
2 include, without limitation, forensic assertive community treatment
3 teams, crisis residential services, criminal justice coordination,
4 peer support, and vocational support.

5 (2) Collaboration between community stakeholders and other
6 partner government agencies in the diversion of individuals with
7 serious mental disorders.

8 (3) Connection of individuals to services in the community after
9 they have completed diversion as provided in this chapter.

10 (e) The department may also provide funding in the contract
11 with the county, subject to appropriation by the Legislature, to
12 cover the cost of providing postbooking assessment of defendants
13 who are likely to be found incompetent to stand trial on felony
14 charges to determine whether the defendant would benefit from
15 diversion as included in the contract.

16 (f) The department may also provide funding in the contract
17 with the county, subject to appropriation by the Legislature, to
18 cover the cost of in-jail treatment prior to the placement in the
19 community for up to an average of 15 days for defendants who
20 have been approved by the court for diversion as included in the
21 contract.

22 (g) A county contracted pursuant to this chapter shall report
23 data and outcomes to the department, within 30 days after the end
24 of each ~~quarter~~, *month*, regarding those individuals targeted by the
25 contract and in the program. This subdivision does not preclude
26 the department from specifying reporting formats or from
27 modifying, reducing, or adding data elements or outcome measures
28 from a contracting county, as needed to provide for reporting of
29 effective data and outcome measures. Notwithstanding any other
30 law, but only to the extent not prohibited by federal law, the county
31 shall provide specific patient information to the department for
32 reporting purposes. The patient information is confidential and is
33 not open to public inspection. A contracting county shall, at a
34 minimum, report all of the following:

35 (1) The number of individuals that the court ordered to
36 postbooking diversion and the length of time for which the
37 defendant has been ordered to diversion.

38 (2) The number of individuals participating in diversion.

39 (3) The name, social security number, criminal identification
40 and information (CII) number, date of birth, and demographics of

1 each individual participating in the program. This information is
2 confidential and is not open to public inspection.

3 (4) The length of time in diversion for each participating
4 individual. This information is confidential and is not open to
5 public inspection.

6 (5) The types of services and supports provided to each
7 individual participating in diversion. This information is
8 confidential and is not open to public inspection.

9 (6) The number of days each individual was in jail prior to
10 placement in diversion. This information is confidential and is not
11 open to public inspection.

12 (7) The number of days that each individual spent in each level
13 of care facility. This information is confidential and is not open to
14 public inspection.

15 (8) The diagnoses of each individual participating in diversion.
16 This information is confidential and is not open to public
17 inspection.

18 (9) The nature and felony or misdemeanor classification of the
19 charges for each individual participating in diversion. This
20 information is confidential and is not open to public inspection.

21 (10) The number of individuals who completed diversion.

22 (11) The name, social security number, CII number, and birth
23 date of each individual who did not complete diversion and the
24 reasons for not completing. This information is confidential and
25 is not open to public inspection.

26 (h) Contracts awarded pursuant to this chapter are exempt from
27 the requirements contained in the Public Contract Code and the
28 State Administrative Manual and are not subject to approval by
29 the Department of General Services.

30 (i) The funds shall not be used to supplant existing services or
31 services reimbursable from an available source but rather to expand
32 upon them or support new services for which existing
33 reimbursement may be limited.

34 (j) (1) Beginning July 1, 2021, subject to appropriation by the
35 Legislature, the department may amend contracts with a county
36 to fund the expansion of an existing department-funded pretrial
37 diversion as described in Chapter 2.8A (commencing with Section
38 1001.35) of Title 6 of Part 2 of the Penal Code, for the population
39 described in subdivision (b) and that meets both of the following
40 criteria:

1 (A) All participants identified for potential diversion are found
2 incompetent to stand trial on a felony charge.

3 (B) Participants diverted through a program expansion suffer
4 from a mental disorder as identified in the most recent edition of
5 the Diagnostic and Statistical Manual of Mental Disorders,
6 excluding antisocial personality disorder, borderline personality
7 disorder, and pedophilia.

8 (2) Counties expanding their programs under this section will
9 not be required to meet any additional match funding requirements.

10 (k) Notwithstanding Chapter 3.5 (commencing with Section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 the state hospitals and the department may implement, interpret,
13 or make specific this section by means of a departmental letter or
14 other similar instruction, as necessary.

15 (l) The department shall have access to the arrest records and
16 state summary of criminal history of defendants who are
17 participating or have participated in the diversion program. The
18 information may be used solely for the purpose of looking at the
19 recidivism rate for those patients.

20 (m) If the defendant is committed directly to a county program
21 in lieu of commitment to the department, counties shall provide
22 the minute order from the court documenting the incompetent to
23 stand trial finding on a felony charge and the original alienist
24 evaluation associated with that finding.

25 (n) For department-funded diversion programs funded through
26 appropriations made by the Budget Act of 2018 or new county
27 programs funded through the Budget Act of 2021, participants in
28 those county programs may include individuals diagnosed with
29 schizophrenia, schizoaffective disorder, or bipolar disorder, who
30 are likely to be found incompetent to stand trial for felony charges,
31 pursuant to Section 1368 of the Penal Code, or who have been
32 found incompetent to stand trial pursuant to clause (iv) of
33 subparagraph (B) of paragraph (1) of subdivision (a) of Section
34 1370 of the Penal Code, until new funds are dispersed to the
35 county. Counties shall continue to comply with all terms of the
36 contract signed with the department, including matching fund and
37 data reporting requirements.

38 *SEC. 36. Section 5014 of the Welfare and Institutions Code is*
39 *amended to read:*

1 5014. (a) To the extent otherwise permitted under state and
2 federal law and consistent with the Mental Health Services Act,
3 both of the following apply for purposes of Article 1 (commencing
4 with Section 5150) and Article 4 (commencing with Section 5250)
5 of Chapter 2 and Chapter 3 (commencing with Section 5350):

6 (1) Counties may pay for the provision of services using funds
7 distributed to the counties from the Mental Health Subaccount,
8 the Mental Health Equity Subaccount, and the Vehicle License
9 Collection Account of the Local Revenue Fund, funds from the
10 Mental Health Account and the Behavioral Health Subaccount
11 within the Support Services Account of the Local Revenue Fund
12 2011, funds from the ~~Mental Behavioral~~ Behavioral Health Services Fund
13 when included in county plans pursuant to Section 5847, and any
14 other funds from which the Controller makes distributions to the
15 counties for those purposes.

16 (2) A person shall not be denied access to services funded by
17 the ~~Mental Behavioral~~ Behavioral Health Services Fund based solely on the
18 person's voluntary or involuntary legal status.

19 (b) The provisions of this section are severable. If any provision
20 of this section or its application is held invalid, that invalidity shall
21 not affect other provisions or applications that can be given effect
22 without the invalid provision or application.

23 *SEC. 37. Section 5349 of the Welfare and Institutions Code is*
24 *amended to read:*

25 5349. (a) A county or group of counties that does not wish to
26 implement this article may opt out of the requirements of this
27 article by a resolution passed by the governing body that state the
28 reasons for opting out and any facts or circumstances relied on in
29 making that decision. To the extent otherwise permitted under
30 state and federal law, counties that implement this article may pay
31 for the provision of services under Sections 5347 and 5348 using
32 funds distributed to the counties from the Mental Health
33 Subaccount, the Mental Health Equity Subaccount, and the Vehicle
34 License Collection Account of the Local Revenue Fund, funds
35 from the Mental Health Account and the Behavioral Health
36 Subaccount within the Support Services Account of the Local
37 Revenue Fund 2011, funds from the ~~Mental Behavioral~~ Behavioral Health
38 Services Fund when included in county plans pursuant to Section
39 5847, and any other funds from which the Controller makes
40 distributions to the counties for those purposes. Compliance with

1 this section shall be monitored by the State Department of Health
2 Care Services as part of the review and approval of city, county,
3 or group of county performance contracts.

4 (b) In lieu of the resolution to opt out pursuant to subdivision
5 (a), a county may elect to implement this article in combination
6 with one or more counties pursuant to the implementation
7 provisions of subdivision (d).

8 (c) A county or group of counties implementing this article shall
9 not reduce existing voluntary mental health programs serving
10 adults or children’s mental health programs as a result of
11 implementation.

12 (d) If multiple counties choose to provide services pursuant to
13 Section 5348, those counties shall execute a memorandum of
14 understanding (MOU) that shall include, but not be limited to, a
15 process for designating the lead county for an individual receiving
16 services pursuant to the MOU for the following purposes:

17 (1) Making the finding set forth in subdivision (d) of Section
18 5346.

19 (2) Ensuring that services are provided and determining where
20 they are provided.

21 (3) Determining the county incurring financial responsibility,
22 as applicable, for an individual receiving services.

23 (4) Ensuring that appropriate followup care is in place upon an
24 individual’s release from the treatment program.

25 (e) This section shall become operative on July 1, 2021.

26 *SEC. 38. Section 5813.5 of the Welfare and Institutions Code,*
27 *as amended by Section 39 of Chapter 790 of the Statutes of 2023,*
28 *is amended to read:*

29 5813.5. Subject to the availability of funds from the ~~Mental~~
30 *Behavioral* Health Services Fund, the state shall distribute funds
31 for the provision of services under Sections 5801, 5802, and 5806
32 to county mental health programs. Services shall be available to
33 adults and seniors with severe illnesses who meet the eligibility
34 criteria in subdivisions (b) and (c) of Section 5600.3. For purposes
35 of this act, “seniors” means older adult persons identified in Part
36 3 (commencing with Section 5800) of this division.

37 (a) Funding shall be provided at sufficient levels to ensure that
38 counties can provide each adult and senior served pursuant to this
39 part with the medically necessary mental health services,

1 medications, and supportive services set forth in the applicable
2 treatment plan.

3 (b) The funding shall only cover the portions of those costs of
4 services that cannot be paid for with other funds, including other
5 mental health funds, public and private insurance, and other local,
6 state, and federal funds.

7 (c) Each county mental health program’s plan shall provide for
8 services in accordance with the system of care for adults and
9 seniors who meet the eligibility criteria in subdivisions (b) and (c)
10 of Section 5600.3.

11 (d) Planning for services shall be consistent with the philosophy,
12 principles, and practices of the Recovery Vision for mental health
13 consumers:

14 (1) To promote concepts key to the recovery for individuals
15 who have mental illness: hope, personal empowerment, respect,
16 social connections, self-responsibility, and self-determination.

17 (2) To promote consumer-operated services as a way to support
18 recovery.

19 (3) To reflect the cultural, ethnic, and racial diversity of mental
20 health consumers.

21 (4) To plan for each consumer’s individual needs.

22 (e) The plan for each county mental health program shall
23 indicate, subject to the availability of funds as determined by Part
24 4.5 (commencing with Section 5890) of this division, and other
25 funds available for mental health services, adults and seniors with
26 a severe mental illness being served by this program are either
27 receiving services from this program or have a mental illness that
28 is not sufficiently severe to require the level of services required
29 of this program.

30 (f) Each county plan and annual update pursuant to Section
31 5847 shall consider ways to provide services similar to those
32 established pursuant to the Mentally Ill Offender Crime Reduction
33 Grant Program. Funds shall not be used to pay for persons
34 incarcerated in state prison. Funds may be used to provide services
35 to persons who are participating in a presentencing or
36 postsentencing diversion program or who are on parole, probation,
37 postrelease community supervision, or mandatory supervision.
38 When included in county plans pursuant to Section 5847, funds
39 may be used for the provision of mental health services under
40 Sections 5347 and 5348 in counties that elect to participate in the

1 Assisted Outpatient Treatment Demonstration Project Act of 2002
2 (Article 9 (commencing with Section 5345) of Chapter 2 of Part
3 1), and for the provision of services to clients pursuant to Part 8
4 (commencing with Section 5970).

5 (g) The department shall contract for services with county
6 mental health programs pursuant to Section 5897. After November
7 2, 2004, the term “grants,” as used in Sections 5814 and 5814.5,
8 shall refer to those contracts.

9 (h) If amendments to the Mental Health Services Act are
10 approved by the voters at the March 5, 2024, statewide primary
11 election, this section shall become inoperative on July 1, 2026,
12 and as of January 1, 2027, is repealed.

13 *SEC. 39. Section 5840 of the Welfare and Institutions Code,*
14 *as added by Section 50 of Chapter 790 of the Statutes of 2023, is*
15 *amended to read:*

16 5840. (a) (1) Each county shall establish and administer an
17 early intervention program that is designed to prevent mental
18 illnesses and substance use disorders from becoming severe and
19 disabling and to reduce disparities in behavioral health.

20 (2) Early intervention programs shall be funded pursuant to
21 clause (ii) of subparagraph (A) of paragraph (3) of subdivision (a)
22 of Section 5892.

23 (b) An early intervention program shall include the following
24 components:

25 (1) Outreach to families, employers, primary care health care
26 providers, behavioral health urgent care, hospitals, inclusive of
27 emergency departments, education, including early care and
28 learning, T-12, and higher education, and others to recognize the
29 early signs of potentially severe and disabling mental health
30 illnesses and substance use disorders.

31 (2) (A) Access and linkage to medically necessary care provided
32 by county behavioral health programs as early in the onset of these
33 conditions as practicable.

34 (B) Access and linkage to care includes the scaling of, and
35 referral to, the Early Psychosis Intervention (EPI) Plus Program,
36 pursuant to Part 3.4 (commencing with Section 5835), Coordinated
37 Specialty Care, or other similar evidence-based practices and
38 community-defined evidence practices for early psychosis and
39 mood disorder detection and intervention programs.

1 (3) (A) Mental health and substance use disorder treatment
2 services, evidence-based practices and community-defined
3 evidence practices for similar to those provided under other
4 programs that are effective in preventing mental health illnesses
5 and substance use disorders from becoming severe, and
6 components similar to programs that have been successful in
7 reducing the duration of untreated serious mental health illnesses
8 and substance use disorders and assisting people in quickly
9 regaining productive lives.

10 (B) Mental health treatment services may include services to
11 address first episode psychosis.

12 (C) Mental health and substance use disorder services shall
13 include services that are demonstrated to be effective at meeting
14 the cultural and linguistic needs of diverse communities.

15 (D) Mental health and substance use disorder services may be
16 provided to the following eligible children and youth:

17 ~~(E) Mental health and substance use services may include~~
18 ~~services that prevent, respond, or treat a behavioral health crisis.~~

19 (i) Individual children and youth at high risk for a behavioral
20 health disorder due to experiencing trauma, as evidenced by scoring
21 in the high-risk range under a trauma screening tool such as an
22 adverse childhood experiences (ACEs) screening tool, involvement
23 in the child welfare system or juvenile justice system, or
24 experiencing homelessness.

25 (ii) Individual children and youth in populations with identified
26 disparities in behavioral health outcomes.

27 *(E) Mental health and substance use services may include*
28 *services that prevent, respond to, or treat a behavioral health*
29 *crisis.*

30 (4) Additional components developed by the State Department
31 of Health Care Services.

32 (c) (1) The State Department of Health Care Services, in
33 consultation with the Behavioral Health Services Oversight and
34 Accountability Commission, counties, and stakeholders, shall
35 establish a biennial list of evidence-based practices and
36 community-defined evidence practices that may include practices
37 identified pursuant to the Children and Youth Behavioral Health
38 Initiative Act set forth in Chapter 2 (commencing with Section
39 5961) of Part 7.

1 (2) Evidence-based practices and community-defined evidence
2 practices may focus on addressing the needs of those who
3 decompensate into severe behavioral health conditions.

4 (3) Local programs utilizing evidence-based practices and
5 community-defined evidence practices may focus on addressing
6 the needs of underserved communities, such as BIPOC and
7 LGBTQ+.

8 (4) Counties shall utilize the list to determine which
9 evidence-based practices and community-defined evidence
10 practices to implement locally.

11 (5) The State Department of Health Care Services may require
12 a county to implement specific evidence-based and
13 community-defined evidence practices.

14 (d) The early intervention program shall emphasize the reduction
15 of the likelihood of:

16 (1) Suicide and self-harm.

17 (2) Incarcerations.

18 (3) School, including early childhood 0 to 5 years of age,
19 inclusive, TK-12, and higher education, suspension, expulsion,
20 referral to an alternative or community school, or failure to
21 complete.

22 (4) Unemployment.

23 (5) Prolonged suffering.

24 (6) Homelessness.

25 (7) Removal of children from their homes.

26 (8) Overdose.

27 (9) Mental illness in children and youth from social, emotional,
28 developmental, and behavioral needs in early childhood.

29 (e) For purposes of this section, “substance use disorder” shall
30 have the meaning as defined in subdivision (c) of Section 5891.5.

31 (f) For purposes of this section, “community-defined evidence
32 practices” is defined as an alternative or complement to
33 evidence-based practices, that offers culturally anchored
34 interventions that reflect the values, practices, histories, and
35 lived-experiences of the communities they serve. These practices
36 come from the community and the organizations that serve them
37 and are found to yield positive results as determined by community
38 consensus over time.

1 (g) This section shall become operative on July 1, 2026, if
2 amendments to the Mental Health Services Act are approved by
3 the voters at the March 5, 2024, statewide primary election.

4 *SEC. 40. Section 5840.6 of the Welfare and Institutions Code,*
5 *as amended by Section 52 of Chapter 790 of the Statutes of 2023,*
6 *is amended to read:*

7 5840.6. For purposes of this chapter, the following definitions
8 shall apply:

9 (a) “Commission” means the Mental Health Services Oversight
10 and Accountability Commission established pursuant to Section
11 5845.

12 (b) “County” also includes a city receiving funds pursuant to
13 Section 5701.5.

14 (c) “Prevention and early intervention funds” means funds from
15 the ~~Mental~~ Behavioral Health Services Fund allocated for
16 prevention and early intervention programs pursuant to paragraph
17 (3) of subdivision (a) of Section 5892.

18 (d) “Childhood trauma prevention and early intervention” refers
19 to a program that targets children exposed to, or who are at risk
20 of exposure to, adverse and traumatic childhood events and
21 prolonged toxic stress in order to deal with the early origins of
22 mental health needs and prevent long-term mental health concerns.
23 This may include, but is not limited to, all of the following:

24 (1) Focused outreach and early intervention to at-risk and
25 in-need populations.

26 (2) Implementation of appropriate trauma and developmental
27 screening and assessment tools with linkages to early intervention
28 services to children that qualify for these services.

29 (3) Collaborative, strengths-based approaches that appreciate
30 the resilience of trauma survivors and support their parents and
31 caregivers when appropriate.

32 (4) Support from peer support specialists and community health
33 workers trained to provide mental health services.

34 (5) Multigenerational family engagement, education, and support
35 for navigation and service referrals across systems that aid the
36 healthy development of children and families.

37 (6) Linkages to primary care health settings, including, but not
38 limited to, federally qualified health centers, rural health centers,
39 community-based providers, school-based health centers, and
40 school-based programs.

1 (7) Leveraging the healing value of traditional cultural
2 connections, including policies, protocols, and processes that are
3 responsive to the racial, ethnic, and cultural needs of individuals
4 served and recognition of historical trauma.

5 (8) Coordinated and blended funding streams to ensure
6 individuals and families experiencing toxic stress have
7 comprehensive and integrated supports across systems.

8 (e) “Early psychosis and mood disorder detection and
9 intervention” has the same meaning as set forth in paragraph (2)
10 of subdivision (b) of Section 5835 and may include programming
11 across the age span.

12 (f) “Youth outreach and engagement” means strategies that
13 target secondary school and transition age youth, with a priority
14 on partnerships with college mental health programs that educate
15 and engage students and provide either on-campus, off-campus,
16 or linkages to mental health services not provided through the
17 campus to students who are attending colleges and universities,
18 including, but not limited to, public community colleges. Outreach
19 and engagement may include, but is not limited to, all of the
20 following:

21 (1) Meeting the mental health needs of students that cannot be
22 met through existing education funds.

23 (2) Establishing direct linkages for students to community-based
24 mental health services.

25 (3) Addressing direct services, including, but not limited to,
26 increasing college mental health staff-to-student ratios and
27 decreasing wait times.

28 (4) Participating in evidence-based and community-defined best
29 practice programs for mental health services.

30 (5) Serving underserved and vulnerable populations, including,
31 but not limited to, lesbian, gay, bisexual, transgender, and queer
32 persons, victims of domestic violence and sexual abuse, and
33 veterans.

34 (6) Establishing direct linkages for students to community-based
35 mental health services for which reimbursement is available
36 through the students’ health coverage.

37 (7) Reducing racial disparities in access to mental health
38 services.

39 (8) Funding mental health stigma reduction training and
40 activities.

1 (9) Providing college employees and students with education
2 and training in early identification, intervention, and referral of
3 students with mental health needs.

4 (10) Interventions for youth with signs of behavioral or
5 emotional problems who are at risk of, or have had any, contact
6 with the juvenile justice system.

7 (11) Integrated youth mental health programming.

8 (12) Suicide prevention programming.

9 (g) “Culturally competent and linguistically appropriate
10 prevention and intervention” refers to a program that creates critical
11 linkages with community-based organizations, including, but not
12 limited to, clinics licensed or operated under subdivision (a) of
13 Section 1204 of the Health and Safety Code, or clinics exempt
14 from clinic licensure pursuant to subdivision (c) of Section 1206
15 of the Health and Safety Code.

16 (1) “Culturally competent and linguistically appropriate” means
17 the ability to reach underserved cultural populations and address
18 specific barriers related to racial, ethnic, cultural, language, gender,
19 age, economic, or other disparities in mental health services access,
20 quality, and outcomes.

21 (2) “Underserved cultural populations” means those who are
22 unlikely to seek help from any traditional mental health service
23 because of stigma, lack of knowledge, or other barriers, including
24 members of ethnically and racially diverse communities, members
25 of the gay, lesbian, bisexual, and transgender communities, and
26 veterans, across their lifespans.

27 (h) “Strategies targeting the mental health needs of older adults”
28 means, but is not limited to, all of the following:

29 (1) Outreach and engagement strategies that target caregivers,
30 victims of elder abuse, and individuals who live alone.

31 (2) Suicide prevention programming.

32 (3) Outreach to older adults who are isolated.

33 (4) Early identification programming of mental health symptoms
34 and disorders, including, but not limited to, anxiety, depression,
35 and psychosis.

36 (i) If amendments to the Mental Health Services Act are
37 approved by the voters at the March 5, 2024, statewide primary
38 election, this section shall become inoperative on July 1, 2026,
39 and as of January 1, 2027, is repealed.

1 *SEC. 41. Section 5845 of the Welfare and Institutions Code,*
2 *as added by Section 58 of Chapter 790 of the Statutes of 2023, is*
3 *amended to read:*

4 5845. (a) The Behavioral Health Services Oversight and
5 Accountability Commission is hereby established to promote
6 transformational change in California’s behavioral health system
7 through research, evaluation and tracking outcomes, and other
8 strategies to assess and report progress. The commission shall use
9 this information and analyses to inform the commission’s grant
10 making, identify key policy issues and emerging best practices,
11 provide technical assistance and training, promote high-quality
12 programs implemented, and advise the Governor and the
13 Legislature, pursuant to the Behavioral Health Services Act and
14 related components of California’s behavioral health system. For
15 this purpose, the commission shall collaborate with the California
16 Health and Human Services Agency, its departments and other
17 state entities.

18 (b) (1) The commission shall replace the advisory committee
19 established pursuant to Section 5814.

20 (2) The commission shall consist of 27 voting members as
21 follows:

22 (A) The Attorney General or the Attorney General’s designee.

23 (B) The Superintendent of Public Instruction or the
24 Superintendent’s designee.

25 (C) The Chairperson of the Senate Committee on Health, the
26 Chairperson of the Senate Committee on Human Services, or
27 another member of the Senate selected by the President pro
28 Tempore of the Senate, or their designee.

29 (D) The Chairperson of the Assembly Committee on Health,
30 the Chairperson of the Assembly Committee on Human Services,
31 or another Member of the Assembly selected by the Speaker of
32 the Assembly, or their designee.

33 (E) (i) The following individuals, all appointed by the Governor:

34 (I) Two persons who have or have had a mental health disorder.

35 (II) Two persons who have or have had a substance use disorder.

36 (III) A family member of an adult or older adult who has or has
37 had a mental health disorder.

38 (IV) One person who is 25 years of age or younger and has or
39 has had a mental health disorder, substance use disorder, or
40 cooccurring disorder.

- 1 (V) A family member of an adult or older adult who has or has
2 had a substance use disorder.
- 3 (VI) A family member of a child or youth who has or has had
4 a mental health disorder.
- 5 (VII) A family member of a child or youth who has or has had
6 a substance use disorder.
- 7 (VIII) A current or former county behavioral health director.
- 8 (IX) A physician specializing in substance use disorder
9 treatment, including the provision of medications for addiction
10 treatment.
- 11 (X) A mental health professional.
- 12 (XI) A professional with expertise in housing and homelessness.
- 13 (XII) A county sheriff.
- 14 (XIII) A superintendent of a school district.
- 15 (XIV) A representative of a labor organization.
- 16 (XV) A representative of an employer with less than 500
17 employees.
- 18 (XVI) A representative of an employer with more than 500
19 employees.
- 20 (XVII) A representative of a health care service plan or insurer.
- 21 (XVIII) A representative of an aging or disability organization.
- 22 (XIX) A person with knowledge and experience in
23 community-defined evidence practices and reducing behavioral
24 health disparities.
- 25 (XX) A representative of a children and youth organization.
- 26 (XXI) A veteran or a representative of a veterans organization.
- 27 (ii) In making appointments, the Governor shall seek individuals
28 who have had personal or family experience with mental illness
29 or substance use disorder.
- 30 (c) Members shall serve without compensation but shall be
31 reimbursed for all actual and necessary expenses incurred in the
32 performance of their duties.
- 33 (d) The term of each member shall be three years, to be
34 staggered so that approximately one-third of the appointments
35 expire in each year.
- 36 (e) (1) The commission shall have an Executive Director.
- 37 (2) The Executive Director will be responsible for management
38 over the administrative, fiscal, and program performance of the
39 commission.
- 40 (3) The Executive Director shall be selected by the commission.

1 (4) *The commission may delegate to the Executive Director any*
2 *power, duty, purpose, function, or jurisdiction that the commission*
3 *may lawfully delegate, including the authority to enter into and*
4 *sign contracts on behalf of the commission. The Executive Director*
5 *may redelegate any of those powers, duties, purposes, functions,*
6 *or jurisdictions to the Executive Director’s designee, unless by*
7 *statute, or rule or regulation, the Executive Director is expressly*
8 *required to act personally.*

9 (f) In carrying out its duties and responsibilities, the commission
10 may do all of the following:

11 (1) (A) Meet at least once each quarter at a time and location
12 convenient to the public as it may deem appropriate.

13 (B) All meetings of the commission shall be open to the public.

14 (2) Within the limit of funds allocated for these purposes,
15 pursuant to the laws and regulations governing state civil service,
16 employ staff, including clerical, legal, and technical assistance, as
17 necessary.

18 (3) The commission shall administer its operations separate and
19 apart from the State Department of Health Care Services and the
20 California Health and Human Services Agency.

21 (4) Establish technical advisory committees, such as a committee
22 of consumers and family members, and a reducing disparities
23 committee focusing on demographic, geographic, and other
24 communities. The commission may provide pertinent information
25 gained from those committees to relevant state agencies and
26 departments, including, but not limited to, the California Health
27 and Humans Services Agency and its departments.

28 (5) Employ all other appropriate strategies necessary or
29 convenient to enable it to fully and adequately perform its duties
30 and exercise the powers expressly granted, notwithstanding
31 authority expressly granted to an officer or employee of state
32 government.

33 (6) Enter into contracts.

34 (7) Make reasonable requests for data and information to the
35 State Department of Health Care Services, the Department of
36 Health Care Access and Information, the State Department of
37 Public Health, or other state and local entities that receive
38 Behavioral Health Services Act funds. These entities shall respond
39 in a timely manner and provide information and data in their

1 possession that the commission deems necessary for the purposes
2 of carrying out its responsibilities.

3 (8) Participate in the joint state-county decisionmaking process,
4 as described in Section 4061, for training, technical assistance,
5 and regulatory resources to meet the mission and goals of the
6 state's mental health system.

7 (9) Identify best practices to overcome stigma and
8 discrimination, in consultation with the State Department of Public
9 Health.

10 (10) At any time, advise the Governor or the Legislature
11 regarding actions the state may take to improve care and services
12 for people with mental illness or substance use disorder.

13 (11) If the commission identifies a critical issue related to the
14 performance of a county mental health program, it may refer the
15 issue to the State Department of Health Care Services pursuant to
16 Section 5655 or 5963.04.

17 (12) Provide technical assistance to counties on implementation
18 planning, training, and capacity building investments as defined
19 by the State Department of Health Care Services and in
20 consultation with the County Behavioral Health Directors
21 Association of California. Technical assistance may also include
22 innovative behavioral health models of care and innovative
23 promising practices pursuant to subparagraph (A) of paragraph
24 (4) of subdivision (a) of Section 5892. Technical assistance may
25 also include compiling and publishing a list of innovative
26 behavioral health models of care programs and promising practices
27 for each of the programs set forth in subparagraphs (1), (2), and
28 (3) of subdivision (a) of Section 5892.

29 (13) Work in collaboration with the State Department of Health
30 Care Services to define the parameters of a report that includes
31 recommendations for improving and standardizing promising
32 practices across the state based on the technical assistance provided
33 to counties as specified in paragraph (12). The commission shall
34 prepare and publish the report on its internet website. In
35 formulating this report, the commission shall prioritize the
36 perspectives of the California behavioral health community through
37 a robust public engagement process with a focus on priority
38 populations and diverse communities.

39 (14) Establish a framework and voluntary standard for mental
40 health in the workplace that serves to reduce mental health stigma,

1 increase public, employee, and employer awareness of the recovery
2 goals of the Mental Health Services Act, and provide guidance to
3 California’s employer community to put in place strategies and
4 programs, as determined by the commission, to support the mental
5 health and wellness of employees. The commission shall consult
6 with the Labor and Workforce Development Agency or its designee
7 to develop the standard.

8 (g) (1) The commission shall work in collaboration with the
9 State Department of Health Care Services and the California
10 Behavioral Health Planning Council, and in consultation with the
11 County Behavioral Health Directors Association of California, to
12 write a report that includes recommendations for improving and
13 standardizing promising practices for Behavioral Health Services
14 Act programs.

15 (2) The commission shall complete the report and provide a
16 written report on its internet website no later than January 1, 2030,
17 and every three years thereafter.

18 (h) For purposes of this section, “substance use disorder” shall
19 have the meaning as defined in subdivision (c) of Section 5891.5.

20 (i) This section shall become operative on January 1, 2025, if
21 amendments to the Mental Health Services Act are approved by
22 the voters at the March 5, 2024, statewide primary election.

23 *SEC. 42. Section 5845.1 of the Welfare and Institutions Code*
24 *is amended to read:*

25 5845.1. (a) (1) The Behavioral Health Services Act Innovation
26 Partnership Fund is hereby created in the State Treasury.

27 (2) The fund shall be administered by the state for the purposes
28 of funding a grant program administered by the Behavioral Health
29 Services Oversight and Accountability Commission pursuant to
30 this section and subdivision (f) of Section 5892.

31 (b) *All of the following may be paid into the fund:*

32 (1) *Any private donation or grant.*

33 (2) *Any other federal or state grant.*

34 (3) *Any interest that accrues on amounts in the fund and any*
35 *moneys previously allocated from private donations or grants*
36 *received by the fund that are subsequently returned to the fund.*

37 ~~(b)~~

38 (c) (1) The Behavioral Health Services Oversight and
39 Accountability Commission shall award grants to private, public,

1 and nonprofit partners to promote development of innovative
2 mental health and substance use disorder programs and practices.

3 (2) The innovative mental health and substance use disorder
4 programs and practices shall be designed for the following
5 purposes:

6 (A) Improving Behavioral Health Services Act programs and
7 practices funded pursuant to subdivision (a) of Section 5892 for
8 the following groups:

9 (i) Underserved populations.

10 (ii) Low-income populations.

11 (iii) Communities impacted by other behavioral health
12 disparities.

13 (iv) Other populations, as determined by the Behavioral Health
14 Services Oversight and Accountability Commission.

15 (B) Meeting statewide Behavioral Health Services Act goals
16 and objectives.

17 (3) The Behavioral Health Services Oversight and
18 Accountability Commission, in determining the allowable uses of
19 the funds, shall consult with the California Health and Human
20 Services Agency and the State Department of Health Care Services.

21 If the Behavioral Health Services Oversight and Accountability
22 Commission utilizes funding for population-based prevention or
23 workforce innovation grants, the commission shall consult with
24 the State Department of Public Health for population-based
25 prevention innovations and the Department of Health Care Access
26 and Information for workforce innovations.

27 (e)

28 (d) (1) The Behavioral Health Services Oversight and
29 Accountability Commission shall submit a report to the Legislature
30 by January 1, 2030, and every three years thereafter. The report
31 shall cover the three-fiscal-year period immediately preceding the
32 date of submission.

33 (2) The report shall include the practices funded pursuant to
34 this section and the extent to which they accomplished the purposes
35 specified in paragraphs (1), (2), and (3) of subdivision (b).

36 (3) A report to be submitted pursuant to paragraph (1) shall be
37 submitted in compliance with Section 9795 of the Government
38 Code.

1 *SEC. 43. Section 5847 of the Welfare and Institutions Code,*
2 *as amended by Section 63 of Chapter 790 of the Statutes of 2023,*
3 *is amended to read:*

4 5847. Integrated Plans for Prevention, Innovation, and System
5 of Care Services.

6 (a) Each county mental health program shall prepare and submit
7 a three-year program and expenditure plan, and annual updates,
8 adopted by the county board of supervisors, to the Mental Health
9 Services Oversight and Accountability Commission and the State
10 Department of Health Care Services within 30 days after adoption.

11 (b) The three-year program and expenditure plan shall be based
12 on available unspent funds and estimated revenue allocations
13 provided by the state and in accordance with established
14 stakeholder engagement and planning requirements, as required
15 in Section 5848. The three-year program and expenditure plan and
16 annual updates shall include all of the following:

17 (1) A program for prevention and early intervention in
18 accordance with Part 3.6 (commencing with Section 5840).

19 (2) A program for services to children in accordance with Part
20 4 (commencing with Section 5850), to include a program pursuant
21 to Chapter 4 (commencing with Section 18250) of Part 6 of
22 Division 9 or provide substantial evidence that it is not feasible to
23 establish a wraparound program in that county.

24 (3) A program for services to adults and seniors in accordance
25 with Part 3 (commencing with Section 5800).

26 (4) A program for innovations in accordance with Part 3.2
27 (commencing with Section 5830).

28 (5) A program for technological needs and capital facilities
29 needed to provide services pursuant to Part 3 (commencing with
30 Section 5800), Part 3.6 (commencing with Section 5840), and Part
31 4 (commencing with Section 5850). All plans for proposed facilities
32 with restrictive settings shall demonstrate that the needs of the
33 people to be served cannot be met in a less restrictive or more
34 integrated setting, such as permanent supportive housing.

35 (6) Identification of shortages in personnel to provide services
36 pursuant to the above programs and the additional assistance
37 needed from the education and training programs established
38 pursuant to Part 3.1 (commencing with Section 5820).

39 (7) Establishment and maintenance of a prudent reserve to
40 ensure the county program will continue to be able to serve

1 children, adults, and seniors that it is currently serving pursuant
2 to Part 3 (commencing with Section 5800), the Adult and Older
3 Adult Mental Health System of Care Act, Part 3.6 (commencing
4 with Section 5840), Prevention and Early Intervention Programs,
5 and Part 4 (commencing with Section 5850), the Children's Mental
6 Health Services Act, during years in which revenues for the ~~Mental~~
7 *Behavioral* Health Services Fund are below recent averages
8 adjusted by changes in the state population and the California
9 Consumer Price Index.

10 (8) Certification by the county behavioral health director, which
11 ensures that the county has complied with all pertinent regulations,
12 laws, and statutes of the Mental Health Services Act, including
13 stakeholder participation and nonsupplantation requirements.

14 (9) Certification by the county behavioral health director and
15 by the county auditor-controller that the county has complied with
16 any fiscal accountability requirements as directed by the State
17 Department of Health Care Services, and that all expenditures are
18 consistent with the requirements of the Mental Health Services
19 Act.

20 (c) The programs established pursuant to paragraphs (2) and
21 (3) of subdivision (b) shall include services to address the needs
22 of transition age youth 16 to 25 years of age, inclusive. In
23 implementing this subdivision, county mental health programs
24 shall consider the needs of transition age foster youth.

25 (d) Each year, the State Department of Health Care Services
26 shall inform the County Behavioral Health Directors Association
27 of California and the Mental Health Services Oversight and
28 Accountability Commission of the methodology used for revenue
29 allocation to the counties.

30 (e) Each county mental health program shall prepare expenditure
31 plans pursuant to Part 3 (commencing with Section 5800) for adults
32 and seniors, Part 3.2 (commencing with Section 5830) for
33 innovative programs, Part 3.6 (commencing with Section 5840)
34 for prevention and early intervention programs, and Part 4
35 (commencing with Section 5850) for services for children, and
36 updates to the plans developed pursuant to this section. Each
37 expenditure update shall indicate the number of children, adults,
38 and seniors to be served pursuant to Part 3 (commencing with
39 Section 5800) and Part 4 (commencing with Section 5850) and
40 the cost per person. The expenditure update shall include utilization

1 of unspent funds allocated in the previous year and the proposed
2 expenditure for the same purpose.

3 (f) A county mental health program shall include an allocation
4 of funds from a reserve established pursuant to paragraph (7) of
5 subdivision (b) for services pursuant to paragraphs (2) and (3) of
6 subdivision (b) in years in which the allocation of funds for services
7 pursuant to subdivision (e) are not adequate to continue to serve
8 the same number of individuals as the county had been serving in
9 the previous fiscal year.

10 (g) The department shall post on its internet website the
11 three-year program and expenditure plans submitted by every
12 county pursuant to subdivision (a) in a timely manner.

13 (h) (1) Notwithstanding subdivision (a), a county that is unable
14 to complete and submit a three-year program and expenditure plan
15 or annual update for the 2020–21 or 2021–22 fiscal years due to
16 the COVID-19 Public Health Emergency may extend the effective
17 timeframe of its currently approved three-year plan or annual
18 update to include the 2020–21 and 2021–22 fiscal years. The
19 county shall submit a three-year program and expenditure plan or
20 annual update to the Mental Health Services Oversight and
21 Accountability Commission and the State Department of Health
22 Care Services by July 1, 2022.

23 (2) For purposes of this subdivision, “COVID-19 Public Health
24 Emergency” means the federal Public Health Emergency
25 declaration made pursuant to Section 247d of Title 42 of the United
26 States Code on January 30, 2020, entitled “Determination that a
27 Public Health Emergency Exists Nationwide as the Result of the
28 2019 Novel Coronavirus,” and any renewal of that declaration.

29 (i) Notwithstanding paragraph (7) of subdivision (b) and
30 subdivision (f), a county may, during the 2020–21 and 2021–22
31 fiscal years, use funds from its prudent reserve for prevention and
32 early intervention programs created in accordance with Part 3.6
33 (commencing with Section 5840) and for services to persons with
34 severe mental illnesses pursuant to Part 4 (commencing with
35 Section 5850) for the children’s system of care and Part 3
36 (commencing with Section 5800) for the adult and older adult
37 system of care. These services may include housing assistance, as
38 defined in Section 5892.5, to the target population specified in
39 Section 5600.3.

1 (j) Notwithstanding Chapter 3.5 (commencing with Section
2 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
3 the department, without taking any further regulatory action, may
4 implement, interpret, or make specific subdivisions (h) and (i) of
5 this section and subdivision (i) of Section 5892 by means of
6 all-county letters or other similar instructions.

7 (k) If amendments to the Mental Health Services Act are
8 approved by the voters at the March 5, 2024, statewide primary
9 election, this section shall become inoperative on July 1, 2026,
10 and as of January 1, 2027, is repealed.

11 *SEC. 44. Section 5849.35 of the Welfare and Institutions Code*
12 *is amended to read:*

13 5849.35. (a) The authority may do all of the following:

14 (1) Consult with the commission and the State Department of
15 Health Care Services concerning the implementation of the No
16 Place Like Home Program, including the review of annual reports
17 provided to the authority by the department pursuant to Section
18 5849.11.

19 (2) Enter into one or more single-year or multiyear contracts
20 with the department for the department to provide, and the authority
21 to pay the department for providing, services described in Sections
22 5849.7, 5849.8, and 5849.9, related to permanent supportive
23 housing for the target population and to provide for payments to
24 the department from amounts on deposit in the Supportive Housing
25 Program Subaccount created within the ~~Mental Behavioral~~ Health
26 Services Fund pursuant to paragraph (1) of subdivision (f) of
27 Section 5890. Before entering into any contract pursuant to this
28 paragraph, the executive director of the authority shall transmit to
29 the commission a copy of the contract in substantially final form.
30 The contract shall be deemed approved by the commission unless
31 it acts within 10 days to disapprove the contract.

32 (3) On or before June 15 and December 15 of each year, the
33 authority shall certify to the Controller the amounts the authority
34 is required to pay as provided in Section 5890 for the following
35 six-month period to the department pursuant to any service contract
36 entered into pursuant to paragraph (2).

37 (b) The department may do all of the following:

38 (1) Enter into one or more single-year or multiyear contracts
39 with the authority to provide services described in Sections 5849.7,
40 5849.8, and 5849.9, related to permanent supportive housing for

1 the target population and to receive payments from amounts on
2 deposit in the Supportive Housing Program Subaccount pursuant
3 to paragraph (1) of subdivision (f) of Section 5890. Payments
4 received by the department under any service contract authorized
5 by this paragraph shall be used, before any other allocation or
6 distribution, to repay loans from the authority pursuant to Section
7 15463 of the Government Code.

8 (2) Enter into one or more loan agreements with the authority
9 as security for the repayment of the revenue bonds issued by the
10 authority pursuant to Section 15463 of the Government Code. The
11 department shall deposit the proceeds of these loans, excluding
12 any refinancing loans to redeem, refund, or retire bonds, into the
13 fund. The department's obligations to make payments under these
14 loan agreements shall be limited obligations payable solely from
15 amounts received pursuant to its service contracts with the
16 authority.

17 (3) The department may pledge and assign its right to receive
18 all or a portion of the payments under the service contracts entered
19 into pursuant to paragraph (1) directly to the authority or its bond
20 trustee for the payment of principal, premiums, if any, and interest
21 under any loan agreement authorized by paragraph (2).

22 (c) The Legislature hereby finds and declares both of the
23 following:

24 (1) The consideration to be paid by the authority to the
25 department for the services provided pursuant to the contracts
26 authorized by paragraph (2) of subdivision (a) and paragraph (1)
27 of subdivision (b) is fair and reasonable and in the public interest.

28 (2) The service contracts and payments made by the authority
29 to the department pursuant to a service contract authorized by
30 paragraph (2) of subdivision (a) and paragraph (1) of subdivision
31 (b) and the loan agreements and loan repayments made by the
32 department to the authority pursuant to a loan agreement authorized
33 by paragraph (2) of subdivision (b) shall not constitute a debt or
34 liability, or a pledge of the faith and credit, of the state or any
35 political subdivision, except as approved by the voters at the
36 November 6, 2018, statewide general election.

37 (d) The state hereby covenants with the holders from time to
38 time of any bonds issued by the authority pursuant to Section 15463
39 of the Government Code that it will not alter, amend, or restrict
40 the provisions of this section, paragraph (1) of subdivision (f) of

1 Section 5890, subdivision (b) of Section 5891, Section 19602.5
2 of the Revenue and Taxation Code, or any other provision requiring
3 the deposit of the revenues derived from the additional tax imposed
4 under Section 17043 of the Revenue and Taxation Code into the
5 ~~Mental Behavioral~~ Health Services Fund in any manner adverse
6 to the interests of those bondholders so long as any of those bonds
7 remain outstanding. The authority may include this covenant in
8 the resolution, indenture, or other documents governing the bonds.

9 (e) Agreements under this section are not subject to, and need
10 not comply with, the requirements of any other law applicable to
11 the execution of those agreements, including, but not limited to,
12 the California Environmental Quality Act (Division 13
13 (commencing with Section 21000) of the Public Resources Code).

14 (f) Chapter 2 (commencing with Section 10290) of Part 2 of
15 Division 2 of the Public Contract Code shall not apply to any
16 contract entered into between the authority and the department
17 under this section.

18 *SEC. 45. Section 5886 of the Welfare and Institutions Code,*
19 *as added by Section 85 of Chapter 790 of the Statutes of 2023, is*
20 *amended to read:*

21 5886. (a) The Behavioral Health Student Services Act is hereby
22 established as a mental health partnership grant program for the
23 purpose of establishing mental health partnerships between a
24 county's mental health or behavioral health departments and school
25 districts, charter schools, and the county office of education within
26 the county.

27 (b) The Behavioral Health Services Oversight and
28 Accountability Commission shall award grants to county mental
29 health or behavioral health departments to fund partnerships
30 between educational and county mental health entities. Subject to
31 an appropriation for this purpose, commencing with the 2021–22
32 fiscal year, the commission shall award a grant under this section
33 to a county mental health or behavioral health department, or
34 another lead agency, as identified by the partnership within each
35 county that meets the requirements of this section.

36 (1) County, city, or multicounty mental health or behavioral
37 health departments, or a consortium of those entities, including
38 multicounty partnerships, may, in partnership with one or more
39 school districts and at least one of the following educational entities

1 located within the county, apply for a grant to fund activities of
2 the partnership:

3 (A) The county office of education.

4 (B) A charter school.

5 (2) (A) An educational entity may be designated as the lead
6 agency at the request of the county, city, or multicounty
7 department, or consortium, and authorized to submit the
8 application.

9 (B) The county, city, or multicounty department, or consortium,
10 shall be the grantee and receive grant funds awarded pursuant to
11 this section, even if an educational entity is designated as the lead
12 agency and submits the application pursuant to this paragraph.

13 (c) The commission shall establish criteria for awarding funds
14 under the grant program, including the allocation of grant funds
15 pursuant to this section, and shall require that applicants comply
16 with, at a minimum, all of the following requirements:

17 (1) That all school districts, charter schools, and the county
18 office of education have been invited to participate in the
19 partnership, to the extent possible.

20 (2) That applicants include with their application a plan
21 developed and approved in collaboration with participating
22 educational entity partners and that include a letter of intent, a
23 memorandum of understanding, or other evidence of support or
24 approval by the governing boards of all partners.

25 (3) That plans address all of the following goals:

26 (A) Preventing mental illnesses from becoming severe and
27 disabling.

28 (B) Improving timely access to services for underserved
29 populations.

30 (C) Providing outreach to families, employers, primary care
31 health care providers, and others to recognize the early signs of
32 potentially severe and disabling mental illnesses.

33 (D) Reducing the stigma associated with the diagnosis of a
34 mental illness or seeking mental health services.

35 (E) Reducing discrimination against people with mental illness.

36 (F) Preventing negative outcomes in the targeted population,
37 including, but not limited to, all of the following:

38 (i) Suicide and attempted suicide.

39 (ii) Incarceration.

40 (iii) School failure or dropout.

- 1 (iv) Unemployment.
- 2 (v) Prolonged suffering.
- 3 (vi) Homelessness.
- 4 (vii) Removal of children and youth from their homes.
- 5 (viii) Involuntary mental health detentions.
- 6 (4) That plans include a description of the following:
- 7 (A) The need for mental health services for children and youth,
- 8 including campus-based mental health services and potential gaps
- 9 in local service connections.
- 10 (B) The proposed use of funds, which shall include, at a
- 11 minimum, that funds will be used to provide personnel or peer
- 12 support.
- 13 (C) How the funds will be used to facilitate linkage and access
- 14 to ongoing and sustained services, including, but not limited to,
- 15 objectives and anticipated outcomes.
- 16 (D) How the partnership will collaborate with preschool and
- 17 childcare providers, or other early childhood service organizations,
- 18 to ensure the mental health needs of children are met before and
- 19 after they transition to a school setting.
- 20 (E) The partnership's ability to do all of the following:
- 21 (i) Obtain federal Medicaid or other reimbursement, including
- 22 Early and Periodic Screening, Diagnostic, and Treatment funds,
- 23 when applicable, or to leverage other funds, when feasible.
- 24 (ii) Collect information on the health insurance carrier for each
- 25 child or youth, with the permission of the child or youth's parent,
- 26 to allow the partnership to seek reimbursement for mental health
- 27 services provided to children and youth, where applicable.
- 28 (iii) Engage a health care service plan or a health insurer in the
- 29 mental health partnership, when applicable, and to the extent
- 30 mutually agreed to by the partnership and the plan or insurer.
- 31 (iv) Administer an effective service program and the degree to
- 32 which mental health providers and educational entities will support
- 33 and collaborate to accomplish the goals of the effort.
- 34 (v) Connect children and youth to a source of ongoing mental
- 35 health services, including, but not limited to, through Medi-Cal,
- 36 specialty mental health plans, county mental health programs, or
- 37 private health coverage.
- 38 (vi) Continue to provide services and activities under this
- 39 program after grant funding has been expended.

1 (d) Grants awarded pursuant to this section shall be used to
2 provide support services that include, at a minimum, all of the
3 following:

4 (1) Services provided on school campuses, to the extent
5 practicable.

6 (2) Suicide prevention services.

7 (3) Drop-out prevention services.

8 (4) Outreach to high-risk youth and young adults, including,
9 but not limited to, foster youth, youth who identify as LGBTQ+,
10 victims of domestic violence and sexual abuse, and youth who
11 have been expelled or suspended from school.

12 (5) Placement assistance and development of a service plan that
13 can be sustained over time for students in need of ongoing services.

14 (e) Funding may also be used to provide other prevention, early
15 intervention, and direct services, including, but not limited to,
16 hiring qualified mental health personnel, professional development
17 for school staff on trauma-informed and evidence-based mental
18 health practices, and other strategies that respond to the mental
19 health needs of children and youth, as determined by the
20 commission.

21 (f) (1) The commission shall determine the amount of grants
22 and shall take into consideration the level of need and the number
23 of schoolage youth in participating educational entities when
24 determining grant amounts.

25 (2) In determining the distribution of funds appropriated in the
26 2021–22 fiscal year, the commission shall take into consideration
27 previous funding the grantee received under this section.

28 (g) The commission may establish incentives to provide
29 matching funds by awarding additional grant funds to partnerships
30 that do so.

31 (h) If the commission is unable to provide a grant to a
32 partnership in a county because of a lack of applicants or because
33 no applicants met the minimum requirements within the timeframes
34 established by the commission, the commission may redistribute
35 those funds to other eligible grantees.

36 (i) Partnerships currently receiving grants from the Investment
37 in Mental Health Wellness Act of 2013 (Part 3.8 (commencing
38 with Section 5848.5)) are eligible to receive a grant under this
39 section for the expansion of services funded by that grant or for

1 the inclusion of additional educational entity partners within the
2 mental health partnership.

3 (j) Grants awarded pursuant to this section may be used to
4 supplement, but not supplant, existing financial and resource
5 commitments of the county, city, or multicounty mental health or
6 behavioral health departments, or a consortium of those entities,
7 or educational entities that receive a grant.

8 (k) (1) The commission shall develop metrics and a system to
9 measure and publicly report on the performance outcomes of
10 services provided using the grants.

11 (2) (A) The commission shall provide a status report to the
12 fiscal and policy committees of the Legislature on the progress of
13 implementation of this section no later than March 1, 2022, and
14 provide an updated report no later than March 1, 2024. The reports
15 shall address, at a minimum, all of the following:

16 (i) Successful strategies.

17 (ii) Identified needs for additional services.

18 (iii) Lessons learned.

19 (iv) Numbers of, and demographic information for, the
20 schoolage children and youth served.

21 (v) Available data on outcomes, including, but not limited to,
22 linkages to ongoing services and success in meeting the goals
23 identified in paragraph (3) of subdivision (c).

24 (B) The reports to be submitted pursuant to this paragraph shall
25 be submitted in compliance with Section 9795 of the Government
26 Code.

27 (l) This section does not require the use of funds allocated for
28 the purpose of satisfying the minimum funding obligation under
29 Section 8 of Article XVI of the California Constitution for the
30 partnerships established by this section.

31 (m) The commission may enter into exclusive or nonexclusive
32 contracts, or amend existing contracts, on a bid or negotiated basis
33 to implement this section. *Contracts entered into or amended*
34 *pursuant to this subdivision are exempt from Chapter 6*
35 *(commencing with Section 14825) of Part 5.5 of Division 3 of Title*
36 *2 of the Government Code, Section 19130 of the Government Code,*
37 *and Part 2 (commencing with Section 10100) of Division 2 of the*
38 *Public Contract Code, and shall be exempt from the review or*
39 *approval of any division of the Department of General Services.*

1 (n) This section shall be implemented only to the extent moneys
2 are appropriated in the annual Budget Act or another statute for
3 purposes of this section.

4 (o) This section shall become operative on January 1, 2025, if
5 amendments to the Mental Health Services Act are approved by
6 the voters at the March 5, 2024, statewide primary election.

7 *SEC. 46. Section 5890 of the Welfare and Institutions Code,*
8 *as amended by Section 87 of Chapter 790 of the Statutes of 2023,*
9 *is amended to read:*

10 5890. (a) The ~~Mental Behavioral~~ Health Services Fund is
11 hereby created in the State Treasury. The fund shall be administered
12 by the state. Notwithstanding Section 13340 of the Government
13 Code, all moneys in the fund are, except as provided in subdivision
14 (d) of Section 5892, continuously appropriated, without regard to
15 fiscal years, for the purpose of funding the following programs
16 and other related activities as designated by other provisions of
17 this division:

18 (1) Part 3 (commencing with Section 5800), the Adult and Older
19 Adult Mental Health System of Care Act.

20 (2) Part 3.2 (commencing with Section 5830), Innovative
21 Programs.

22 (3) Part 3.6 (commencing with Section 5840), Prevention and
23 Early Intervention Programs.

24 (4) Part 3.9 (commencing with Section 5849.1), No Place Like
25 Home Program.

26 (5) Part 4 (commencing with Section 5850), the Children's
27 Mental Health Services Act.

28 (b) The establishment of this fund and any other provisions of
29 the act establishing it or the programs funded shall not be construed
30 to modify the obligation of health care service plans and disability
31 insurance policies to provide coverage for mental health services,
32 including those services required under Section 1374.72 of the
33 Health and Safety Code and Section 10144.5 of the Insurance
34 Code, related to mental health parity. This act shall not be
35 construed to modify the oversight duties of the Department of
36 Managed Health Care or the duties of the Department of Insurance
37 with respect to enforcing these obligations of plans and insurance
38 policies.

1 (c) This act shall not be construed to modify or reduce the
2 existing authority or responsibility of the State Department of
3 Health Care Services.

4 (d) The State Department of Health Care Services shall seek
5 approval of all applicable federal Medicaid approvals to maximize
6 the availability of federal funds and eligibility of participating
7 children, adults, and seniors for medically necessary care.

8 (e) Share of costs for services pursuant to Part 3 (commencing
9 with Section 5800) and Part 4 (commencing with Section 5850)
10 of this division, shall be determined in accordance with the
11 Uniform Method of Determining Ability to Pay applicable to other
12 publicly funded mental health services, unless this Uniform Method
13 is replaced by another method of determining copayments, in which
14 case the new method applicable to other mental health services
15 shall be applicable to services pursuant to Part 3 (commencing
16 with Section 5800) and Part 4 (commencing with Section 5850)
17 of this division.

18 (f) (1) The Supportive Housing Program Subaccount is hereby
19 created in the ~~Mental Behavioral Health Services Fund~~.
20 Notwithstanding Section 13340 of the Government Code, all
21 moneys in the subaccount are reserved and continuously
22 appropriated, without regard to fiscal years, to the California Health
23 Facilities Financing Authority to provide funds to meet its financial
24 obligations pursuant to any service contracts entered into pursuant
25 to Section 5849.35. Notwithstanding any other law, including any
26 other provision of this section, no later than the last day of each
27 month, the Controller shall, before any transfer or expenditure
28 from the fund for any other purpose for the following month,
29 transfer from the ~~Mental Behavioral Health Services Fund~~ to the
30 Supportive Housing Program Subaccount an amount that has been
31 certified by the California Health Facilities Financing Authority
32 pursuant to paragraph (3) of subdivision (a) of Section 5849.35,
33 but not to exceed an aggregate amount of one hundred forty million
34 dollars (\$140,000,000) per year. If, in any month, the amounts in
35 the ~~Mental Behavioral Health Services Fund~~ are insufficient to
36 fully transfer to the subaccount or the amounts in the subaccount
37 are insufficient to fully pay the amount certified by the California
38 Health Facilities Financing Authority, the shortfall shall be carried
39 over to the next month, to be transferred by the Controller with
40 any transfer required by the preceding sentence. Moneys in the

1 Supportive Housing Program Subaccount shall not be loaned to
2 the General Fund pursuant to Section 16310 or 16381 of the
3 Government Code.

4 (2) Prior to the issuance of any bonds pursuant to Section 15463
5 of the Government Code, the Legislature may appropriate for
6 transfer funds in the ~~Mental~~ Behavioral Health Services Fund to
7 the Supportive Housing Program Subaccount in an amount up to
8 one hundred forty million dollars (\$140,000,000) per year. Any
9 amount appropriated for transfer pursuant to this paragraph and
10 deposited in the No Place Like Home Fund shall reduce the
11 authorized but unissued amount of bonds that the California Health
12 Facilities Financing Authority may issue pursuant to Section 15463
13 of the Government Code by a corresponding amount.
14 Notwithstanding Section 13340 of the Government Code, all
15 moneys in the subaccount transferred pursuant to this paragraph
16 are reserved and continuously appropriated, without regard to fiscal
17 years, for transfer to the No Place Like Home Fund, to be used for
18 purposes of Part 3.9 (commencing with Section 5849.1). The
19 Controller shall, before any transfer or expenditure from the fund
20 for any other purpose for the following month but after any transfer
21 from the fund for purposes of paragraph (1), transfer moneys
22 appropriated from the ~~Mental~~ Behavioral Health Services Fund to
23 the subaccount pursuant to this paragraph in equal amounts over
24 the following 12-month period, beginning no later than 90 days
25 after the effective date of the appropriation by the Legislature. If,
26 in any month, the amounts in the ~~Mental~~ Behavioral Health
27 Services Fund are insufficient to fully transfer to the subaccount
28 or the amounts in the subaccount are insufficient to fully pay the
29 amount appropriated for transfer pursuant to this paragraph, the
30 shortfall shall be carried over to the next month.

31 (3) The sum of any transfers described in paragraphs (1) and
32 (2) shall not exceed an aggregate of one hundred forty million
33 dollars (\$140,000,000) per year.

34 (4) Paragraph (2) shall become inoperative once any bonds
35 authorized pursuant to Section 15463 of the Government Code are
36 issued.

37 (g) If amendments to the Mental Health Services Act are
38 approved by the voters at the March 5, 2024, statewide primary
39 election, this section shall become inoperative on July 1, 2026,
40 and as of January 1, 2027, is repealed.

1 *SEC. 47. Section 5891 of the Welfare and Institutions Code,*
2 *as amended by Section 89 of Chapter 790 of the Statutes of 2023,*
3 *is amended to read:*

4 5891. (a) (1) (A) The funding established pursuant to this act
5 shall be utilized to expand mental health services.

6 (B) Except as provided in subdivision (j) of Section 5892 due
7 to the state’s fiscal crisis, these funds shall not be used to supplant
8 existing state or county funds utilized to provide mental health
9 services.

10 (C) The state shall continue to provide financial support for
11 mental health programs with not less than the same entitlements,
12 amounts of allocations from the General Fund or from the Local
13 Revenue Fund 2011 in the State Treasury, and formula distributions
14 of dedicated funds as provided in the last fiscal year which ended
15 prior to the effective date of this act.

16 (D) The state shall not make any change to the structure of
17 financing mental health services, which increases a county’s share
18 of costs or financial risk for mental health services unless the state
19 includes adequate funding to fully compensate for such increased
20 costs or financial risk.

21 (E) These funds shall only be used to pay for the programs
22 authorized in Sections 5890 and 5892. These funds may not be
23 used to pay for any other program.

24 (F) These funds may not be loaned to the General Fund or any
25 other fund of the state, or a county general fund or any other county
26 fund for any purpose other than those authorized by Sections 5890
27 and 5892.

28 (2) To maximize federal financial participation in furtherance
29 of subdivision (d) of Section 5890, a county shall submit claims
30 for reimbursement to the State Department of Health Care Services
31 in accordance with applicable Medi-Cal rules and procedures for
32 a behavioral health service or supportive service eligible for
33 reimbursement pursuant to Title XIX or XXI of the federal Social
34 Security Act (42 U.S.C. Sec. 1396, et seq. and 1397aa, et seq.)
35 when such service is paid, in whole or in part, using the funding
36 established pursuant to this act.

37 (3) (A) To maximize funding from other sources, a county shall
38 seek reimbursement for a behavioral health service, supportive
39 service, housing intervention, or other related activity provided,
40 pursuant to subdivision (a) of Section 5892, that is covered by or

1 can be paid from another available funding source, including other
2 mental health funds, substance use disorder funds, public and
3 private insurance, and other local, state, and federal funds. This
4 paragraph does not require counties to exhaust other funding
5 sources before using ~~behavioral health services fund~~ *Behavioral*
6 *Health Service Fund* moneys to pay for a service-related activity.

7 (B) A county shall make a good faith effort to enter into
8 contracts, single case agreements, or other agreements to obtain
9 reimbursement with health care service plans and disability
10 insurance plans, pursuant to Section 1374.72 of the Health and
11 Safety Code and Section 10144.5 of the Insurance Code.

12 (C) A county shall also submit requests for prior authorization
13 for services, request letters of agreement for payment as an
14 out-of-network provider, and pursue other means to obtain
15 reimbursement in accordance with state and federal laws.

16 (b) (1) Notwithstanding subdivision (a), and except as provided
17 in paragraph (2), the Controller may use the funds created pursuant
18 to this part for loans to the General Fund as provided in Sections
19 16310 and 16381 of the Government Code. Any such loan shall
20 be repaid from the General Fund with interest computed at 110
21 percent of the Pooled Money Investment Account rate, with interest
22 commencing to accrue on the date the loan is made from the fund.
23 This subdivision does not authorize any transfer that would
24 interfere with the carrying out of the object for which these funds
25 were created.

26 (2) This subdivision does not apply to the Supportive Housing
27 Program Subaccount created by subdivision (f) of Section 5890
28 or any moneys paid by the California Health Facilities Financing
29 Authority to the Department of Housing and Community
30 Development as a service fee pursuant to a service contract
31 authorized by Section 5849.35.

32 (c) Commencing July 1, 2012, on or before the 15th day of each
33 month, pursuant to a methodology provided by the State
34 Department of Health Care Services, the Controller shall distribute
35 to each Local Mental Health Service Fund established by counties
36 pursuant to subdivision (f) of Section 5892, all unexpended and
37 unreserved funds on deposit as of the last day of the prior month
38 in the ~~Mental~~ *Behavioral* Health Services Fund, established
39 pursuant to Section 5890, for the provision of programs and other
40 related activities set forth in Part 3 (commencing with Section

1 5800), Part 3.2 (commencing with Section 5830), Part 3.6
2 (commencing with Section 5840), Part 3.9 (commencing with
3 Section 5849.1), and Part 4 (commencing with Section 5850).

4 (d) (1) Counties shall base their expenditures on the county
5 mental health program's three-year program and expenditure plan
6 or annual update, as required by Section 5847.

7 (2) This subdivision does not affect subdivision (a) or (b).

8 (e) This act shall not be construed to modify or reduce a health
9 plan's obligations under the Knox-Keene Health Care Service Plan
10 Act of 1975.

11 (f) This section shall become operative immediately if
12 amendments to the Mental Health Services Act are approved by
13 the voters at the March 5, 2024, statewide primary election.

14 (g) If amendments to the Mental Health Services Act are
15 approved by the voters at the March 5, 2024, statewide primary
16 election, this section shall become inoperative on July 1, 2026,
17 and as of January 1, 2027, is repealed.

18 *SEC. 48. Section 5892 of the Welfare and Institutions Code,*
19 *as added by Section 94 of Chapter 790 of the Statutes of 2023, is*
20 *amended to read:*

21 5892. (a) To promote efficient implementation of this act, the
22 county shall use funds distributed from the ~~Mental Behavioral~~
23 Health Services Fund as follows:

24 (1) Twenty percent of funds distributed to the counties pursuant
25 to subdivision (c) of Section 5891 shall be used for prevention and
26 early intervention programs in accordance with Part 3.6
27 (commencing with Section 5840).

28 (2) The expenditure for prevention and early intervention may
29 be increased in a county in which the department determines that
30 the increase will decrease the need and cost for additional services
31 to persons with severe mental illness in that county by an amount
32 at least commensurate with the proposed increase.

33 (3) The balance of funds shall be distributed to county mental
34 health programs for services to persons with severe mental illnesses
35 pursuant to Part 4 (commencing with Section 5850) for the
36 children's system of care and Part 3 (commencing with Section
37 5800) for the adult and older adult system of care. These services
38 may include housing assistance, as defined in Section 5892.5, to
39 the target population specified in Section 5600.3.

1 (4) Five percent of the total funding for each county mental
2 health program for Part 3 (commencing with Section 5800), Part
3 3.6 (commencing with Section 5840), and Part 4 (commencing
4 with Section 5850) shall be utilized for innovative programs in
5 accordance with Sections 5830, 5847, and 5963.03.

6 (b) (1) Programs for services pursuant to Part 3 (commencing
7 with Section 5800) and Part 4 (commencing with Section 5850)
8 may include funds for technological needs and capital facilities,
9 human resource needs, and a prudent reserve to ensure services
10 do not have to be significantly reduced in years in which revenues
11 are below the average of previous years. The total allocation for
12 purposes authorized by this subdivision shall not exceed 20 percent
13 of the average amount of funds allocated to that county for the
14 previous five fiscal years pursuant to this section.

15 (2) A county shall calculate a maximum amount it establishes
16 as the prudent reserve for its Local Behavioral Health Services
17 Fund, not to exceed 33 percent of the average of the total funds
18 distributed to the county pursuant to subdivision (c) of Section
19 5891 in the preceding five years.

20 (3) A county with a population of less than 200,000 shall
21 calculate a maximum amount it establishes as the prudent reserve
22 for its Local Behavioral Health Services Fund, not to exceed 25
23 percent of the average of the total funds distributed to the county
24 pursuant to subdivision (c) of Section 5891 in the preceding five
25 years.

26 (c) Notwithstanding subdivision (a) of Section 5891, the
27 allocations pursuant to subdivisions (a) and (b) shall include
28 funding for annual planning costs pursuant to Sections 5847 and
29 5963.03. The total of these costs shall not exceed 5 percent of the
30 total of annual revenues received for the Local Behavioral Health
31 Services Fund. The planning costs shall include funds for county
32 mental health programs to pay for the costs of consumers, family
33 members, and other stakeholders to participate in the planning
34 process and for the planning and implementation required for
35 private provider contracts to be significantly expanded to provide
36 additional services pursuant to Part 3 (commencing with Section
37 5800) and Part 4 (commencing with Section 5850).

38 (d) (1) Notwithstanding subdivision (a) of Section 5891, the
39 allocations pursuant to subdivision (a) may include funding to
40 improve plan operations, quality outcomes, fiscal and

1 programmatic data reporting, and monitoring of subcontractor
2 compliance for all county behavioral health programs, including,
3 but not limited to, programs administered by a Medi-Cal behavioral
4 health delivery system, as defined in subdivision (i) of Section
5 14184.101, and programs funded by the Projects for Assistance
6 in Transition from Homelessness grant, the Community Mental
7 Health Services Block Grant, and other Substance Abuse and
8 Mental Health Services Administration grants.

9 (2) The total of these costs shall not exceed 2 percent of the
10 total of annual revenues received for the Local Behavioral Health
11 Services Fund.

12 (3) A county may commence use of funding pursuant to this
13 paragraph on July 1, 2025.

14 (e) (1) (A) Prior to making the allocations pursuant to
15 subdivisions (a), (b), (c), and (d), funds shall be reserved for state
16 directed purposes for the California Health and Human Services
17 Agency, the State Department of Health Care Services, the
18 California Behavioral Health Planning Council, the Department
19 of Health Care Access and Information, the Behavioral Health
20 Services Oversight and Accountability Commission, the State
21 Department of Public Health, and any other state agency.

22 (B) These costs shall not exceed 5 percent of the total of annual
23 revenues received for the fund.

24 (C) The costs shall include funds to assist consumers and family
25 members to ensure the appropriate state and county agencies give
26 full consideration to concerns about quality, structure of service
27 delivery, or access to services.

28 (D) The amounts allocated for state directed purposes shall
29 include amounts sufficient to ensure adequate research and
30 evaluation regarding the effectiveness of services being provided
31 and achievement of the outcome measures set forth in Part 3
32 (commencing with Section 5800), Part 3.6 (commencing with
33 Section 5840), and Part 4 (commencing with Section 5850).

34 (E) The amount of funds available for the purposes of this
35 subdivision in any fiscal year is subject to appropriation in the
36 annual Budget Act.

37 (2) Prior to making the allocations pursuant to subdivisions (a),
38 (b), (c), and (d), funds shall be reserved for the costs of the
39 Department of Health Care Access and Information to administer
40 a behavioral health workforce initiative in collaboration with the

1 California Health and Human Services Agency. Funding for this
2 purpose shall not exceed thirty-six million ~~dollars~~ *dollars*
3 *(\$36,000,000)*. The amount of funds available for the purposes of
4 this subdivision in any fiscal year is subject to appropriation in the
5 annual Budget Act.

6 (f) Each county shall place all funds received from the State
7 ~~Mental Behavioral~~ Health Services Fund in a local Mental Health
8 Services Fund. The Local Mental Health Services Fund balance
9 shall be invested consistent with other county funds and the interest
10 earned on the investments shall be transferred into the fund. The
11 earnings on investment of these funds shall be available for
12 distribution from the fund in future fiscal years.

13 (g) All expenditures for county mental health programs shall
14 be consistent with a currently approved plan or update pursuant
15 to Section 5847.

16 (h) (1) Other than funds placed in a reserve in accordance with
17 an approved plan, any funds allocated to a county that have not
18 been spent for their authorized purpose within three years, and the
19 interest accruing on those funds, shall revert to the state to be
20 deposited into the Reversion Account, hereby established in the
21 fund, and available for other counties in future years, provided,
22 however, that funds, including interest accrued on those funds, for
23 capital facilities, technological needs, or education and training
24 may be retained for up to 10 years before reverting to the Reversion
25 Account.

26 (2) (A) If a county receives approval from the Mental Health
27 Services Oversight and Accountability Commission of a plan for
28 innovative programs, pursuant to subdivision (e) of Section 5830,
29 the county's funds identified in that plan for innovative programs
30 shall not revert to the state pursuant to paragraph (1) so long as
31 they are encumbered under the terms of the approved project plan,
32 including any subsequent amendments approved by the
33 commission, or until three years after the date of approval,
34 whichever is later.

35 (B) Subparagraph (A) applies to all plans for innovative
36 programs that have received commission approval and are in the
37 process at the time of enactment of the act that added this
38 subparagraph, and to all plans that receive commission approval
39 thereafter.

1 (3) Notwithstanding paragraph (1), funds allocated to a county
2 with a population of less than 200,000 that have not been spent
3 for their authorized purpose within five years shall revert to the
4 state as described in paragraph (1).

5 (4) (A) Notwithstanding paragraphs (1) and (2), if a county
6 with a population of less than 200,000 receives approval from the
7 Mental Health Services Oversight and Accountability Commission
8 of a plan for innovative programs, pursuant to subdivision (e) of
9 Section 5830, the county's funds identified in that plan for
10 innovative programs shall not revert to the state pursuant to
11 paragraph (1) so long as they are encumbered under the terms of
12 the approved project plan, including any subsequent amendments
13 approved by the commission, or until five years after the date of
14 approval, whichever is later.

15 (B) Subparagraph (A) applies to all plans for innovative
16 programs that have received commission approval and are in the
17 process at the time of enactment of the act that added this
18 subparagraph, and to all plans that receive commission approval
19 thereafter.

20 (i) Notwithstanding subdivision (h) and Section 5892.1, unspent
21 funds allocated to a county, and interest accruing on those funds,
22 which are subject to reversion as of July 1, 2019, and July 1, 2020,
23 shall be subject to reversion on July 1, 2021.

24 (j) If there are revenues available in the fund after the State
25 Department of Health Care Services has determined there are
26 prudent reserves and no unmet needs for any of the programs
27 funded pursuant to this section, the department, in consultation
28 with counties, shall develop a plan for expenditures of these
29 revenues to further the purposes of this act and the Legislature
30 may appropriate these funds for any purpose consistent with the
31 department's plan that furthers the purposes of this act.

32 (k) This section shall become operative on January 1, 2025, if
33 amendments to the Mental Health Services Act are approved by
34 the voters at the March 5, 2024, statewide primary election.

35 (l) This section shall become inoperative on July 1, 2026, if
36 amendments to the Mental Health Services Act are approved by
37 the voters at the March 5, 2024, statewide primary election.

38 *SEC. 49. Section 5892.5 of the Welfare and Institutions Code,*
39 *as amended by Section 99 of Chapter 790 of the Statutes of 2023,*
40 *is amended to read:*

1 5892.5. (a) (1) The California Housing Finance Agency, with
2 the concurrence of the State Department of Health Care Services,
3 shall release unencumbered ~~Mental Behavioral~~ Health Services
4 Fund moneys dedicated to the Mental Health Services Act housing
5 program upon the written request of the respective county. The
6 county shall use these ~~Mental Behavioral~~ Health Services Fund
7 moneys released by the agency to provide housing assistance to
8 the target populations who are identified in Section 5600.3.

9 (2) For purposes of this section, “housing assistance” means
10 each of the following:

11 (A) Rental assistance or capitalized operating subsidies.

12 (B) Security deposits, utility deposits, or other move-in cost
13 assistance.

14 (C) Utility payments.

15 (D) Moving cost assistance.

16 (E) Capital funding to build or rehabilitate housing for homeless,
17 mentally ill persons or mentally ill persons who are at risk of being
18 homeless.

19 (b) For purposes of administering those funds released to a
20 respective county pursuant to subdivision (a), the county shall
21 comply with all of the requirements described in the Mental Health
22 Services Act, including, but not limited to, Sections 5664, 5847,
23 subdivision (h) of Section 5892, and 5899.

24 (c) If amendments to the Mental Health Services Act are
25 approved by the voters at the March 5, 2024, statewide primary
26 election, this section shall become inoperative on July 1, 2026,
27 and as of January 1, 2027, is repealed.

28 *SEC. 50. Section 5893 of the Welfare and Institutions Code,*
29 *as amended by Section 101 of Chapter 790 of the Statutes of 2023,*
30 *is amended to read:*

31 5893. (a) In any year in which the funds available exceed the
32 amount allocated to counties, such funds shall be carried forward
33 to the next fiscal year to be available for distribution to counties
34 in accordance with Section 5892 in that fiscal year.

35 (b) All funds deposited into the ~~Mental Behavioral~~ Health
36 Services Fund shall be invested in the same manner in which other
37 state funds are invested. The fund shall be increased by its share
38 of the amount earned on investments.

39 (c) If amendments to the Mental Health Services Act are
40 approved by the voters at the March 5, 2024, statewide primary

1 election, this section shall become inoperative on July 1, 2026,
2 and as of January 1, 2027, is repealed.

3 *SEC. 51. Section 5895 of the Welfare and Institutions Code,*
4 *as amended by Section 103 of Chapter 790 of the Statutes of 2023,*
5 *is amended to read:*

6 5895. (a) If any provisions of Part 3 (commencing with Section
7 5800) or Part 4 (commencing with Section 5850) are repealed or
8 modified so the purposes of this act cannot be accomplished, the
9 funds in the ~~Mental~~ Behavioral Health Services Fund shall be
10 administered in accordance with those sections as they read on
11 January 1, 2004.

12 (b) If amendments to the Mental Health Services Act are
13 approved by the voters at the March 5, 2024, statewide primary
14 election, this section shall become inoperative on July 1, 2026,
15 and as of January 1, 2027, is repealed.

16 *SEC. 52. Section 5899 of the Welfare and Institutions Code,*
17 *as amended by Section 108 of Chapter 790 of the Statutes of 2023,*
18 *is amended to read:*

19 5899. (a) (1) The State Department of Health Care Services,
20 in consultation with the Mental Health Services Oversight and
21 Accountability Commission and the County Behavioral Health
22 Directors Association of California, shall develop and administer
23 instructions for the Annual Mental Health Services Act Revenue
24 and Expenditure Report.

25 (2) The instructions shall include a requirement that the county
26 certify the accuracy of this report.

27 (3) With the exception of expenditures and receipts related to
28 the capital facilities and technology needs component described
29 in paragraph (6) of subdivision (d), each county shall adhere to
30 uniform accounting standards and procedures that conform to the
31 Generally Accepted Accounting Principles prescribed by the
32 Controller pursuant to Section 30200 of the Government Code
33 when accounting for receipts and expenditures of Mental Health
34 Services Act (MHSA) funds in preparing the report.

35 (4) Counties shall report receipts and expenditures related to
36 capital facilities and technology needs using the cash basis of
37 accounting, which recognizes expenditures at the time payment is
38 made.

1 (5) Each county shall electronically submit the report to the
2 department and to the Mental Health Services Oversight and
3 Accountability Commission.

4 (6) The department and the commission shall annually post each
5 county's report in a text-searchable format on its internet website
6 in a timely manner.

7 (b) The department, in consultation with the commission and
8 the County Behavioral Health Directors Association of California,
9 shall revise the instructions described in subdivision (a) by July
10 1, 2017, and as needed thereafter, to improve the timely and
11 accurate submission of county revenue and expenditure data.

12 (c) The purpose of the Annual Mental Health Services Act
13 Revenue and Expenditure Report is as follows:

14 (1) Identify the expenditures of MHSA funds that were
15 distributed to each county.

16 (2) Quantify the amount of additional funds generated for the
17 mental health system as a result of the MHSA.

18 (3) Identify unexpended funds and interest earned on MHSA
19 funds.

20 (4) Determine reversion amounts, if applicable, from prior fiscal
21 year distributions.

22 (d) This report is intended to provide information that allows
23 for the evaluation of all of the following:

24 (1) Children's systems of care.

25 (2) Prevention and early intervention strategies.

26 (3) Innovative projects.

27 (4) Workforce education and training.

28 (5) Adults and older adults systems of care.

29 (6) Capital facilities and technology needs.

30 (e) If a county does not submit the annual revenue and
31 expenditure report described in subdivision (a) by the required
32 deadline, the department may withhold MHSA funds until the
33 reports are submitted.

34 (f) A county shall also report the amount of MHSA funds that
35 were spent on mental health services for veterans.

36 (g) By October 1, 2018, and by October 1 of each subsequent
37 year, the department shall, in consultation with counties, publish
38 on its internet website a report detailing funds subject to reversion
39 by county and by originally allocated purpose. The report also

1 shall include the date on which the funds will revert to the ~~Mental~~
2 *Behavioral Health Services Fund.*

3 (h) If amendments to the Mental Health Services Act are
4 approved by the voters at the March 5, 2024, statewide primary
5 election, this section shall become inoperative on July 1, 2026,
6 and as of January 1, 2027, is repealed.

7 *SEC. 53. Section 5961.4 of the Welfare and Institutions Code*
8 *is amended to read:*

9 5961.4. (a) As a component of the initiative, the State
10 Department of Health Care Services shall develop and maintain a
11 school-linked statewide fee schedule for outpatient mental health
12 or substance use disorder treatment provided to a student 25 years
13 of age or younger at a schoolsite.

14 (b) The department shall develop and maintain a school-linked
15 statewide provider network of schoolsite behavioral health
16 counselors.

17 (c) (1) Commencing January 1, 2024, and subject to subdivision
18 ~~(d)~~, (h), each Medi-Cal managed care plan and Medi-Cal behavioral
19 health delivery system, as applicable, shall reimburse providers
20 of medically necessary outpatient mental health or substance use
21 disorder treatment provided at a schoolsite to a student 25 years
22 of age or younger who is an enrollee of the plan or delivery system,
23 in accordance with paragraph (2), but only to the extent the
24 Medi-Cal managed care plan or Medi-Cal behavioral delivery
25 system is financially responsible for those schoolsite services under
26 its approved managed care contract with the department.

27 (2) Providers of medically necessary schoolsite services
28 described in this section shall be reimbursed, at a minimum, at the
29 fee schedule rate or rates developed pursuant to subdivision (a),
30 regardless of network provider status.

31 (d) (1) *The department may contract with an entity to administer*
32 *the school-linked statewide behavioral health provider network*
33 *in accordance with this subdivision.*

34 (2) *The entity that administers the school-linked statewide*
35 *behavioral health provider network shall do all of the following:*

36 (A) *Create and administer a process for enrolling and*
37 *credentialing all eligible practitioners and providers seeking to*
38 *provide medically necessary schoolsite services described in this*
39 *section.*

1 (B) Create and administer a process for the submission and
2 reimbursement of claims eligible to be reimbursed pursuant to this
3 section, which may include resolving disputes related to the
4 school-linked statewide all-payer fee schedule and administering
5 fee collection pursuant to subdivision (g).

6 (C) Create and administer a mechanism for the sharing of data
7 between the entity contracted pursuant to this subdivision and a
8 health care service plan, insurer, or Medi-Cal managed care plan
9 that covers medically necessary schoolsite services subject to the
10 school-linked statewide all-payer fee schedule that is necessary
11 to facilitate timely claims processing, payment, and reporting,
12 avoid duplication of claims, allow for tracking of grievance
13 remediation, and to facilitate coordination of care and continuity
14 of care for enrollees.

15 (e) A provider or practitioner of medically necessary schoolsite
16 services participating in the school-linked statewide behavioral
17 health provider network described in this section shall do all of
18 the following:

19 (1) Comply with all administrative requirements necessary to
20 be enrolled and credentialed, as applicable, by the entity that
21 administers the school-linked statewide behavioral health provider
22 network.

23 (2) Submit all claims for reimbursement for services billed under
24 the school-linked statewide all-payer fee schedule through the
25 entity that administers the school-linked statewide behavioral
26 health provider network.

27 (3) If a provider or practitioner of medically necessary
28 schoolsite services has, or enters into, a direct agreement
29 established with a health care service plan, insurer, or Medi-Cal
30 managed care plan that covers medically necessary schoolsite
31 services outside of the school-linked statewide all-payer fee
32 schedule, they shall be allowed to bill for services provided directly
33 under the terms of the established agreement.

34 (f) (1) A health care service plan, insurer, or Medi-Cal managed
35 care plan that covers medically necessary schoolsite services
36 subject to the school-linked statewide all-payer fee schedule,
37 pursuant to Section 1374.722 of the Health and Safety Code,
38 Section 10144.53 of the Insurance Code, and this section, shall
39 comply with all administrative requirements necessary to cover

1 *and reimburse those services set forth by the entity that administers*
2 *the school-linked statewide behavioral health provider network.*

3 *(2) If an agreement exists between a health care service plan,*
4 *insurer, or Medi-Cal managed care plan and a provider or*
5 *practitioner of medically necessary schoolsite services outside of*
6 *the school-linked statewide all-payer fee schedule, the health care*
7 *service plan, insurer, or Medi-Cal managed care plan shall do all*
8 *of the following:*

9 *(A) At minimum, reimburse the contracted provider or*
10 *practitioner at the school-linked statewide all-payer fee schedule*
11 *rates.*

12 *(B) Provide to the department data deemed necessary and*
13 *appropriate for program reporting and compliance purposes.*

14 *(C) Comply with all administrative requirements necessary to*
15 *cover and reimburse medically necessary schoolsite services*
16 *subject to the school-linked statewide all-payer fee schedule, as*
17 *determined by the department.*

18 *(g) (1) The department shall establish and charge a fee to*
19 *participating health care service plans, insurers, or Medi-Cal*
20 *managed care plans to cover the reasonable cost of administering*
21 *the school-linked statewide behavioral health provider network.*

22 *(2) The department shall set the fees in an amount that it projects*
23 *is sufficient to cover all administrative costs incurred by the state*
24 *associated with implementing this section and consider the assessed*
25 *volume of claims and providers or practitioners of medically*
26 *necessary schoolsite services that are credentialed and enrolled*
27 *by the entity contracted pursuant to subdivision (d).*

28 *(3) The department shall not assess the fee authorized by this*
29 *subdivision until the time that the contract between the department*
30 *and the entity contracted pursuant to subdivision (d) commences.*

31 *(4) (A) The department may periodically update the amount*
32 *and structure of the fees, as necessary, to provide sufficient funding*
33 *for the purpose specified in this subdivision.*

34 *(B) The fees authorized in this paragraph shall be evaluated*
35 *annually and based on the state's projected costs for the*
36 *forthcoming fiscal year.*

37 *(C) If the department proposes to increase the fees, it shall notify*
38 *the Legislature of the proposed increase through the submission*
39 *of the semiannual Medi-Cal estimate provided to the Legislature.*

1 (5) (A) (i) *The Behavioral Health Schoolsite Fee Schedule*
2 *Administration Fund is hereby established in the State Treasury.*

3 (ii) *The department shall administer the Behavioral Health*
4 *Schoolsite Fee Schedule Administration Fund consistent with this*
5 *subdivision.*

6 (B) *All revenues, less refunds, derived from the fees authorized*
7 *in this subdivision shall be deposited in the Behavioral Health*
8 *Schoolsite Fee Schedule Administration Fund.*

9 (C) *The moneys in the Behavioral Health Schoolsite Fee*
10 *Schedule Administration Fund shall be available upon*
11 *appropriation by the Legislature and shall be used only for*
12 *purposes of this subdivision.*

13 (D) *Notwithstanding Section 16305.7 of the Government Code,*
14 *interest and dividends earned on moneys in the Behavioral Health*
15 *Schoolsite Fee Schedule Administration Fund shall be retained in*
16 *the fund and used solely for the purposes specified in this section.*

17 (E) *Notwithstanding any other provision of law, the Controller*
18 *may use moneys in the Behavioral Health Schoolsite Fee Schedule*
19 *Administration Fund for cashflow loans to the General Fund as*
20 *provided in Sections 16310 and 16381 of the Government Code.*

21 (F) *Funds remaining in the Behavioral Health Schoolsite Fee*
22 *Schedule Administration Fund at the end of a fiscal year shall be*
23 *available for use in the following fiscal year and taken into*
24 *consideration in establishment of fees for the subsequent fiscal*
25 *year.*

26 ~~(G)~~

27 (h) *This section shall be implemented only to the extent that the*
28 *department obtains any necessary federal approvals, and federal*
29 *financial participation under the Medi-Cal program is available*
30 *and not otherwise jeopardized.*

31 ~~(e)~~

32 (i) *This section does not relieve a local educational agency or*
33 *institution of higher education from requirements to accommodate*
34 *or provide services to students with disabilities pursuant to any*
35 *applicable state and federal law, including, but not limited to, the*
36 *federal Individuals with Disabilities Education Act (20 U.S.C. Sec.*
37 *1400 et seq.), Part 30 (commencing with Section 56000) of*
38 *Division 4 of Title 2 of the Education Code, Chapter 26.5*
39 *(commencing with Section 7570) of Division 7 of Title 1 of the*

1 Government Code, and Chapter 3 (commencing with Section 3000)
2 of Division 1 of Title 5 of the California Code of Regulations.

3 (f)

4 (j) For purposes of this section, the following definitions shall
5 apply:

6 (1) “Comprehensive risk contract” has the same meaning as set
7 forth in Section 438.2 of Title 42 of the Code of Federal
8 Regulations.

9 (2) “Institution of higher education” means the California
10 Community Colleges, the California State University, or the
11 University of California.

12 (3) Local educational agency” means a school district, county
13 office of education, charter school, the California Schools for the
14 Deaf, and the California School for the Blind.

15 (4) “Medi-Cal behavioral health delivery system” has the
16 meaning described in subdivision (i) of Section 14184.101.

17 (5) “Medi-Cal managed care plan” means any individual,
18 organization, or entity that enters into a comprehensive risk contract
19 with the department to provide covered full-scope health care
20 services to enrolled Medi-Cal beneficiaries pursuant to any
21 provision of Chapter 7 (commencing with Section 14000) or
22 Chapter 8 (commencing with Section 14200) of Part 3 of Division
23 9.

24 (6) “Schoolsite” has the meaning described in paragraph (6) of
25 subdivision (b) of Section 1374.722 of the Health and Safety Code.

26 *SEC. 54. Section 7296 is added to the Welfare and Institutions*
27 *Code, to read:*

28 *7296. (a) To the extent administratively feasible and within*
29 *available resources, the State Department of State Hospitals shall*
30 *do all of the following:*

31 *(1) Provide any eligible patient with assistance in obtaining an*
32 *original or replacement identification card pursuant to subdivision*
33 *(i) of Section 14902 of the Vehicle Code.*

34 *(2) Facilitate the process between a patient and those entities*
35 *holding documentation, such as a birth certificate or social security*
36 *card, required for a patient to obtain an identification card. This*
37 *assistance shall include, without limitation, the provision of any*
38 *necessary notary services, assistance with obtaining forms, and*
39 *any required correspondence.*

1 (3) Provide an eligible patient with the verification of eligibility
2 described in clause (iii) of subparagraph (A) of paragraph (1) of
3 subdivision (i) of Section 14902 of the Vehicle Code.

4 (b) For purposes of this section, “eligible patient” means a
5 patient who is currently housed in a facility described in Section
6 4100, is preparing to be discharged unconditionally or through a
7 conditional release program, and who qualifies to obtain an
8 original or replacement identification pursuant to subdivision (i)
9 of Section 14902 of the Vehicle Code.

10 SEC. 55. Section 14105.192 of the Welfare and Institutions
11 Code is amended to read:

12 14105.192. (a) The Legislature finds and declares all of the
13 following:

14 (1) Costs within the Medi-Cal program continue to grow due
15 to the rising cost of providing health care throughout the state and
16 also due to increases in enrollment, which are more pronounced
17 during difficult economic times.

18 (2) In order to minimize the need for drastically cutting
19 enrollment standards or benefits during times of economic crisis,
20 it is crucial to find areas within the Medi-Cal program that have
21 reimbursement levels higher than required under the standard
22 provided in Section 1902(a)(30)(A) of the federal Social Security
23 Act and may be reduced in accordance with federal law.

24 (3) The Medi-Cal program delivers its services and benefits to
25 Medi-Cal beneficiaries through a wide variety of health care
26 providers, some of which deliver care via managed care or other
27 contract models while others do so through fee-for-service
28 arrangements.

29 (4) The setting of rates within the Medi-Cal program is complex
30 and subject to close supervision by the United States Department
31 of Health and Human Services.

32 (5) As the single state agency for the Medicaid program in
33 California, the department has unique expertise that can inform
34 decisions that set or adjust reimbursement methodologies and
35 levels consistent with the requirements of federal law.

36 (b) Therefore, it is the intent of the Legislature for the
37 department to analyze and identify where reimbursement levels
38 can be reduced consistent with the standard provided in Section
39 1902(a)(30)(A) of the federal Social Security Act and consistent
40 with federal and state law and policies, including exemptions

1 contained in the act that added this section, provided that the
2 reductions in reimbursement shall not exceed 10 percent on an
3 aggregate basis for all providers, services, and products.

4 (c) Notwithstanding any other law, the director shall adjust
5 provider payments, as specified in this section.

6 (d) (1) Except as otherwise provided in this section, payments
7 shall be reduced by 10 percent for Medi-Cal fee-for-service benefits
8 for dates of service on and after June 1, 2011.

9 (2) For managed health care plans that contract with the
10 department pursuant to this chapter or Chapter 8 (commencing
11 with Section 14200), except contracts with Senior Care Action
12 Network and AIDS Healthcare Foundation, payments shall be
13 reduced by the actuarial equivalent amount of the payment
14 reductions specified in this section pursuant to contract
15 amendments or change orders effective on July 1, 2011, or
16 thereafter.

17 (3) Payments shall be reduced by 10 percent for non-Medi-Cal
18 programs described in Article 6 (commencing with Section 124025)
19 of Chapter 3 of Part 2 of Division 106 of the Health and Safety
20 Code, and Section 14105.18, for dates of service on and after June
21 1, 2011. This paragraph shall not apply to inpatient hospital
22 services provided in a hospital that is paid under contract pursuant
23 to Article 2.6 (commencing with Section 14081).

24 (4) (A) Notwithstanding any other law, the director may adjust
25 the payments specified in paragraphs (1) and (3) with respect to
26 one or more categories of Medi-Cal providers, or for one or more
27 products or services rendered, or any combination thereof, if the
28 resulting reductions to any category of Medi-Cal providers, in the
29 aggregate, total no more than 10 percent.

30 (B) The adjustments authorized in subparagraph (A) shall be
31 implemented only if the director determines that, for each affected
32 product, service, or provider category, the payments resulting from
33 the adjustment comply with subdivision (m).

34 (e) Notwithstanding this section, payments to hospitals that are
35 not under contract with the department pursuant to Article 2.6
36 (commencing with Section 14081) for inpatient hospital services
37 provided to Medi-Cal beneficiaries and that are subject to former
38 Section 14166.245 shall be governed by that section.

39 (f) Notwithstanding this section, both of the following apply:

1 (1) Payments to providers that are paid pursuant to Article 3.8
2 (commencing with Section 14126) shall be governed by that article.

3 (2) (A) Subject to subparagraph (B), for dates of service on and
4 after June 1, 2011, Medi-Cal reimbursement rates for intermediate
5 care facilities for the developmentally disabled licensed pursuant
6 to subdivision (e), (g), or (h) of Section 1250 of the Health and
7 Safety Code, and facilities providing continuous skilled nursing
8 care to developmentally disabled individuals pursuant to the pilot
9 project established by Section 14132.20, as determined by the
10 applicable methodology for setting reimbursement rates for these
11 facilities, shall not exceed the reimbursement rates that were
12 applicable to providers in the 2008–09 rate year.

13 (B) (i) If Section 14105.07 is added to the Welfare and
14 Institutions Code during the 2011–12 Regular Session of the
15 Legislature, subparagraph (A) shall become inoperative.

16 (ii) If Section 14105.07 is added to the Welfare and Institutions
17 Code during the 2011–12 Regular Session of the Legislature, then
18 for dates of service on and after June 1, 2011, payments to
19 intermediate care facilities for the developmentally disabled
20 licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of
21 the Health and Safety Code, and facilities providing continuous
22 skilled nursing care to developmentally disabled individuals
23 pursuant to the pilot project established by Section 14132.20, shall
24 be governed by the applicable methodology for setting
25 reimbursement rates for these facilities and by Section 14105.07.

26 (g) The department may enter into contracts with a vendor for
27 the purposes of implementing this section on a bid or nonbid basis.
28 In order to achieve maximum cost savings, the Legislature declares
29 that an expedited process for contracts under this subdivision is
30 necessary. Therefore, contracts entered into to implement this
31 section and all contract amendments and change orders shall be
32 exempt from Chapter 2 (commencing with Section 10290) of Part
33 2 Division 2 of the Public Contract Code.

34 (h) To the extent applicable, all of the following services,
35 facilities, and payments shall be exempt from the payment
36 reductions specified in subdivision (d):

37 (1) Acute hospital inpatient services that are paid under contracts
38 pursuant to Article 2.6 (commencing with Section 14081).

39 (2) Federally qualified health center services, including those
40 facilities deemed to have federally qualified health center status

- 1 pursuant to a waiver pursuant to subsection (a) of Section 1115 of
2 the federal Social Security Act (42 U.S.C. Sec. 1315(a)).
- 3 (3) Rural health clinic services.
- 4 (4) Payments to facilities owned or operated by the State
5 Department of State Hospitals or the State Department of
6 Developmental Services.
- 7 (5) Hospice services.
- 8 (6) Contract services, as designated by the director pursuant to
9 subdivision (k).
- 10 (7) Payments to providers to the extent that the payments are
11 funded by means of a certified public expenditure or an
12 intergovernmental transfer pursuant to Section 433.51 of Title 42
13 of the Code of Federal Regulations. This paragraph shall apply to
14 payments described in paragraph (3) of subdivision (d) only to the
15 extent that they are also exempt from reduction pursuant to
16 subdivision (l).
- 17 (8) Services pursuant to local assistance contracts and
18 interagency agreements to the extent the funding is not included
19 in the funds appropriated to the department in the annual Budget
20 Act.
- 21 (9) Breast and cervical cancer treatment provided pursuant to
22 Section 14007.71 and as described in paragraph (3) of subdivision
23 (a) of Section 14105.18 or Article 1.5 (commencing with Section
24 104160) of Chapter 2 of Part 1 of Division 103 of the Health and
25 Safety Code.
- 26 (10) The Family Planning, Access, Care, and Treatment (Family
27 PACT) Program pursuant to subdivision (aa) of Section 14132.
- 28 (11) (A) Effective for dates of service on or after July 1, 2015,
29 or the effective date of any necessary federal approvals as required
30 by subdivisions (n) and (o), whichever is later, dental services and
31 applicable ancillary services.
- 32 (B) For dental managed care plans that contract with the
33 department pursuant to this chapter or Chapter 8 (commencing
34 with Section 14200), payments pursuant to contract amendments
35 or change orders effective on or after July 1, 2015, or the effective
36 date of any necessary federal approvals as required by subdivisions
37 (n) and (o), whichever is later.
- 38 (12) For dates of service on and after January 1, 2022, or the
39 effective date of any necessary federal approvals as required by
40 subdivisions (n) and (o), whichever is later, providers of complex

1 rehabilitation technology and complex rehabilitation technology
2 services, as described in Section 14132.85.

3 (13) For dates of service on and after July 1, 2022, or the
4 effective date of any necessary federal approvals as required by
5 subdivisions (n) and (o), whichever is later, all of the following
6 services and providers:

7 (A) Nurses, including certified nurse-midwives, nurse
8 anesthetists, certified pediatric nurse practitioners, certified family
9 nurse practitioners, and group certified pediatric nurse practitioners.

10 (B) Alternative birth centers as described in Section 14148.8.

11 (C) Audiologists and hearing aid dispensers as described in
12 Section 14105.49 of this code and Section 51319 of Title 22 of
13 the California Code of Regulations.

14 (D) Respiratory care providers as described in Section 51316
15 of Title 22 of the California Code of Regulations.

16 (E) Durable medical equipment, as described in Section 51160
17 of Title 22 of the California Code of Regulations.

18 (F) Chronic dialysis clinics.

19 (G) Emergency medical air transportation services as described
20 in Section 76000.10 of the Government Code.

21 (H) Nonemergency medical transportation services as described
22 in Section 51323 of Title 22 of the California Code of Regulations.

23 (I) Doula services as described in Section 14132.24.

24 (J) Community health worker services as described in the
25 approved Medi-Cal State Plan.

26 (K) Durable medical equipment and related supplies or
27 accessories, as described in Section 14105.48 and Section 51160
28 of Title 22 of the California Code of Regulations, that is a
29 continuous glucose monitoring system or continuous glucose
30 monitoring system supplies and accessories, as determined by the
31 department.

32 (L) Health care services delivered via remote patient monitoring,
33 authorized pursuant to subparagraph (B) of paragraph (1) of
34 subdivision (f) of Section 14124.12.

35 (M) Asthma prevention services as described in the approved
36 Medi-Cal State Plan.

37 (N) Dyadic services as described in Section 14132.755.

38 (O) Medication therapy management services as described in
39 Section 14132.969.

- 1 (P) Clinical laboratory services, as defined in Section 51137.2
2 of Title 22 of the California Code of Regulations, that are 2019
3 Novel Coronavirus (COVID-19) diagnostic testing or specimen
4 collection services, as determined by the department.
- 5 (Q) Blood banks, as described in Section 51052 of Title 22 of
6 the California Code of Regulations.
- 7 (R) Occupational therapy, as described in Section 51085 of the
8 California Code of Regulations.
- 9 (S) Orthotists, as described in Section 51101 of Title 22 of the
10 California Code of Regulations.
- 11 (T) Psychologists, as described in Section 51099 of Title 22 of
12 the California Code of Regulations.
- 13 (U) Medical social work or medical social services, as described
14 in Section 51147 of Title 22 of the California Code of Regulations.
- 15 (V) Speech pathologists, as described in Section 51095 of Title
16 22 of the California Code of Regulations.
- 17 (W) Outpatient heroin detoxification services, as described in
18 Section 51116 of Title 22 of the California Code of Regulations.
- 19 (X) Dispensing opticians, as described in Section 51090 of Title
20 22 of the California Code of Regulations.
- 21 (Y) Optometrists, including optometry groups, as described in
22 Section 51091 of Title 22 of the California Code of Regulations.
- 23 (Z) Acupuncturists, as described in Section 51074 of Title 22
24 of the California Code of Regulations.
- 25 (AA) Portable imaging services, as described in Section 51193.1
26 of Title 22 of the California Code of Regulations.
- 27 (AB) The following primary care or specialty clinics, as
28 determined by the department:
- 29 (i) Community clinics, as defined in Section 1204 of the Health
30 and Safety Code.
- 31 (ii) Free clinics, as defined in Section 1204 of the Health and
32 Safety Code.
- 33 (iii) Surgical clinics, as defined in Section 1204 of the Health
34 and Safety Code.
- 35 (iv) Rehabilitation clinics, as defined in Section 1204 of the
36 Health and Safety Code.
- 37 (v) Clinics exempt from licensure under Section 1206 of the
38 Health and Safety Code, including nonhospital county-operated
39 community clinics.

1 (AC) Services provided under the California Children’s Services
2 Program, established pursuant to Article 5 (commencing with
3 Section 123845) of Chapter 3 of Part 2 of Division 106 of the
4 Health and Safety Code, and under the Genetically Handicapped
5 Persons Program, established pursuant to Article 1 (commencing
6 with Section 125125) of Chapter 2 of Part 5 of Division 106 of
7 the Health and Safety Code, as determined by the department.

8 (AD) Community-Based Adult Services (CBAS), as described
9 in Section 14186.3 and as covered pursuant to subdivision (e) of
10 Section 14184.201.

11 (14) For dates of service on and after January 1, 2023, or the
12 effective date of any necessary federal approvals as required by
13 subdivisions (n) and (o), whichever is later, both of the following
14 providers:

15 (A) Podiatrists, as described in Section 51075 of Title 22 of the
16 California Code of Regulations.

17 (B) Prosthetists, as described in Section 51103 of Title 22 of
18 the California Code of Regulations.

19 (15) For dates of service on and after January 1, 2024, or the
20 effective date of the payments implemented pursuant to subdivision
21 (a) of Section 14105.201, whichever is later, all of the following
22 services and providers:

23 (A) Primary care services, including those provided by
24 physicians or nonphysician health professionals, as defined in
25 Section 51170.5 of Title 22 of the California Code of Regulations.

26 (B) Obstetric care services and doula services as described in
27 Section 14132.24.

28 (C) Outpatient mental health services that are not the financial
29 responsibility of county mental health plans operating pursuant to
30 Chapter 8.9 (commencing with Section 14700).

31 (16) (A) *For dates of service on and after January 1, 2025, or*
32 *the effective dates of the payments implemented pursuant to*
33 *Sections 14124.163 and 14124.165, whichever is later, as*
34 *applicable, all of the following services and providers:*

35 (i) *Physician and professional services subject to reimbursement*
36 *pursuant to Section 14124.163.*

37 (ii) *Abortion services, as defined in subdivision (d) of Section*
38 *14124.161, subject to reimbursement pursuant to Section*
39 *14124.165.*

1 (B) *If the voters approve the addition of Chapter 7.5*
2 *(commencing with Section 14199.100) to this part at the November*
3 *5, 2024, statewide general election, this paragraph shall be*
4 *inoperative as of January 1, 2025.*

5 (i) Subject to the exception for services listed in subdivision
6 (h), the payment reductions required by subdivision (d) shall apply
7 to the benefits rendered by any provider who may be authorized
8 to bill for the service, including, but not limited to, physicians,
9 podiatrists, nurse practitioners, certified nurse-midwives, nurse
10 anesthetists, and organized outpatient clinics.

11 (j) Notwithstanding any other law, for dates of service on and
12 after June 1, 2011, Medi-Cal reimbursement rates applicable to
13 the following classes of providers shall not exceed the
14 reimbursement rates that were applicable to those classes of
15 providers in the 2008–09 rate year, as described in subdivision (f)
16 of Section 14105.191, reduced by 10 percent:

17 (1) Intermediate care facilities, excluding those facilities
18 identified in paragraph (2) of subdivision (f). For purposes of this
19 section, “intermediate care facility” has the same meaning as
20 defined in Section 51118 of Title 22 of the California Code of
21 Regulations.

22 (2) Skilled nursing facilities that are distinct parts of general
23 acute care hospitals. For purposes of this section, “distinct part”
24 has the same meaning as defined in Section 72041 of Title 22 of
25 the California Code of Regulations.

26 (3) Rural swing-bed facilities.

27 (4) Subacute care units that are, or are parts of, distinct parts of
28 general acute care hospitals. For purposes of this paragraph,
29 “subacute care unit” has the same meaning as defined in Section
30 51215.5 of Title 22 of the California Code of Regulations.

31 (5) Pediatric subacute care units that are, or are parts of, distinct
32 parts of general acute care hospitals. For purposes of this paragraph,
33 “pediatric subacute care unit” has the same meaning as defined in
34 Section 51215.8 of Title 22 of the California Code of Regulations.

35 (6) Adult day health care centers.

36 (7) Freestanding pediatric subacute care units, as defined in
37 Section 51215.8 of Title 22 of the California Code of Regulations.

38 (k) Notwithstanding Chapter 3.5 (commencing with Section
39 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
40 the department may implement and administer this section by

1 means of provider bulletins or similar instructions, without taking
2 regulatory action.

3 (l) The reductions described in this section shall apply only to
4 payments for services when the General Fund share of the payment
5 is paid with funds directly appropriated to the department in the
6 annual Budget Act and shall not apply to payments for services
7 paid with funds appropriated to other departments or agencies.

8 (m) Notwithstanding this section, the payment reductions and
9 adjustments provided for in subdivision (d) shall be implemented
10 only if the director determines that the payments that result from
11 the application of this section comply with applicable federal
12 Medicaid program requirements and that federal financial
13 participation will be available.

14 (1) In determining whether federal financial participation is
15 available, the director shall determine whether the payments
16 comply with applicable federal Medicaid program requirements,
17 including those set forth in Section 1396a(a)(30)(A) of Title 42 of
18 the United States Code.

19 (2) To the extent that the director determines that the payments
20 do not comply with the federal Medicaid program requirements
21 or that federal financial participation is not available with respect
22 to any payment that is reduced pursuant to this section, the director
23 shall retain the discretion to not implement the particular payment
24 reduction or adjustment and may adjust the payment as necessary
25 to comply with federal Medicaid program requirements.

26 (n) The department shall seek any necessary federal approvals
27 for the implementation of this section.

28 (o) (1) The payment reductions and adjustments set forth in
29 this section shall not be implemented until federal approval is
30 obtained.

31 (2) To the extent that federal approval is obtained for one or
32 more of the payment reductions and adjustments in this section
33 and Section 14105.07, the payment reductions and adjustments
34 set forth in Section 14105.191 shall cease to be implemented for
35 the same services provided by the same class of providers. If there
36 is a conflict between this section and Section 14105.191, other
37 than the provisions setting forth a payment reduction or adjustment,
38 this section shall govern.

39 (3) When federal approval is obtained, the payments resulting
40 from the application of this section shall be implemented

1 retroactively to June 1, 2011, or on any other date or dates, as may
2 be applicable.

3 (4) The director may clarify the application of this subdivision
4 by means of provider bulletins or similar instructions, pursuant to
5 subdivision (k).

6 (p) Adjustments to pharmacy drug product payment pursuant
7 to this section shall no longer apply when the department
8 determines that the average acquisition cost methodology pursuant
9 to Section 14105.45 has been fully implemented and the
10 department's pharmacy budget reduction targets, consistent with
11 payment reduction levels pursuant to this section, have been met.

12 *SEC. 56. Section 14105.200 of the Welfare and Institutions*
13 *Code is amended to read:*

14 14105.200. (a) The Medi-Cal Provider Payment Reserve Fund
15 is hereby created in the State Treasury.

16 (b) Notwithstanding Section 16305.7 of the Government Code,
17 any interest and dividends earned on moneys in the Medi-Cal
18 Provider Payment Reserve Fund shall be retained in the fund and
19 used solely for the purposes specified in this section.

20 (c) (1) Subject to an appropriation made by the Legislature, the
21 department shall use the funds transferred to the Medi-Cal Provider
22 Payment Reserve Fund pursuant to paragraph (3) of subdivision
23 (d) of Section 14199.82 for purposes of funding targeted increases
24 to Medi-Cal payments or other investments that advance access,
25 quality, and equity for Medi-Cal beneficiaries and promote provider
26 participation in the Medi-Cal program.

27 (2) The expenditures of funds appropriated pursuant to paragraph
28 (1) shall include, but not be limited to, all of the following:

29 (A) Increased costs incurred as a result of the reimbursement
30 requirements established in Section 14105.201.

31 (B) Transfers authorized in paragraph (2) of subdivision (e) of
32 Section 129385 of the Health and Safety Code.

33 ~~(C) Transfers, or an appropriation in the annual Budget Act, to~~
34 ~~the University of California in the amount of seventy-five million~~
35 ~~dollars (\$75,000,000) each calendar year to expand graduate~~
36 ~~medical education programs, in order to achieve the goal of~~
37 ~~increasing the number of primary care and specialty care physicians~~
38 ~~in the state based on demonstrated workforce needs and priorities.~~

39 ~~(D)~~

1 (C) Transfers, or an appropriation in the annual Budget Act, to
2 the Small and Rural Hospital Relief Fund, as established in Section
3 130077 of the Health and Safety Code, in the amount of fifty
4 million dollars (\$50,000,000) in state fiscal year 2023–24 to
5 support the Small and Rural Hospital Relief Program for seismic
6 assessment and construction.

7 ~~(E)~~

8 (D) Effective no sooner than January 1, 2025, increased costs
9 for targeted increases to Medi-Cal payments or other investments
10 pursuant to the plan described in Section 14105.202: authorized
11 pursuant to Article 3.1 (commencing with Section 14124.160).

12 (E) Transfers in the amount of forty million dollars
13 (\$40,000,000) in state fiscal year 2026–27 to support workforce
14 investments as implemented by the Department of Health Care
15 Access and Information.

16 (F) Increased costs incurred as a result of the provision of
17 continuous eligibility to children up to five years of age pursuant
18 to Sections 15832 and 15853 of this code and Section 12693.74
19 of the Insurance Code.

20 (G) Reimbursement of the department’s administrative costs
21 incurred in administering and implementing Article 3.1
22 (commencing with Section 14124.160).

23 (d) The department shall provide an annual report to all health
24 plans accounting for the funds deposited in, and expended from,
25 the Medi-Cal Provider Payment Reserve Fund, in a time and
26 manner as deemed appropriate by the director.

27 (e) Notwithstanding any other law, the Controller may use the
28 funds in the Medi-Cal Provider Payment Reserve Fund for
29 cashflow loans to the General Fund as provided in Sections 16310
30 and 16381 of the Government Code.

31 (f) *If the voters approve the addition of Chapter 7.5*
32 *(commencing with Section 14199.100) to this part at the November*
33 *5, 2024, statewide general election, this section is repealed as of*
34 *January 1, 2025.*

35 SEC. 57. Section 14105.200 is added to the Welfare and
36 Institutions Code, to read:

37 14105.200. (a) The Medi-Cal Provider Payment Reserve Fund
38 is hereby created in the State Treasury.

39 (b) Notwithstanding Section 16305.7 of the Government Code,
40 any interest and dividends earned on moneys in the Medi-Cal

1 *Provider Payment Reserve Fund shall be retained in the fund and*
2 *used solely for the purposes specified in this section.*

3 *(c) (1) Subject to an appropriation made by the Legislature,*
4 *the department shall use the funds transferred to the Medi-Cal*
5 *Provider Payment Reserve Fund pursuant to paragraph (3) of*
6 *subdivision (d) of Section 14199.82 for purposes of funding*
7 *targeted increases to Medi-Cal payments or other investments that*
8 *advance access, quality, and equity for Medi-Cal beneficiaries*
9 *and promote provider participation in the Medi-Cal program.*

10 *(2) The expenditures of funds appropriated pursuant to*
11 *paragraph (1) shall include, but not be limited to, all of the*
12 *following:*

13 *(A) Increased costs incurred as a result of the reimbursement*
14 *requirements established in Section 14105.201.*

15 *(B) Transfers authorized in paragraph (2) of subdivision (e) of*
16 *Section 129385 of the Health and Safety Code.*

17 *(C) Transfers, or an appropriation in the annual Budget Act,*
18 *to the Small and Rural Hospital Relief Fund, as established in*
19 *Section 130077 of the Health and Safety Code, in the amount of*
20 *fifty million dollars (\$50,000,000) in state fiscal year 2023–24 to*
21 *support the Small and Rural Hospital Relief Program for seismic*
22 *assessment and construction.*

23 *(d) The department shall provide an annual report to all health*
24 *plans accounting for the funds deposited in, and expended from,*
25 *the Medi-Cal Provider Payment Reserve Fund, in a time and*
26 *manner deemed appropriate by the director.*

27 *(e) Notwithstanding any other law, the Controller may use the*
28 *funds in the Medi-Cal Provider Payment Reserve Fund for*
29 *cashflow loans to the General Fund as provided in Sections 16310*
30 *and 16381 of the Government Code.*

31 *(f) If the voters approve the addition of Chapter 7.5*
32 *(commencing with Section 14199.100) to this part at the November*
33 *5, 2024, statewide general election, this section shall become*
34 *operative on January 1, 2025.*

35 *SEC. 58. Section 14105.201 of the Welfare and Institutions*
36 *Code is amended to read:*

37 *14105.201. (a) (1) Notwithstanding any other law, for dates*
38 *of service no sooner than January 1, 2024, or on the effective date*
39 *of any necessary federal approvals as required by subdivision ~~(d)~~,*
40 *(e), whichever is later, the reimbursement rates for the following*

1 services, as determined in accordance with subdivision ~~(f)~~, (g),
2 shall be the greater of 87.5 percent of the lowest maximum
3 allowance established by the federal Medicare Program for the
4 same or similar services or the level of reimbursement, which shall
5 account for, and be inclusive of, the exemption of these services
6 from payment reductions pursuant to Section 14105.192, and
7 supplemental payments or rate increases, or both, as applicable,
8 under the California Healthcare, Research and Prevention Tobacco
9 Tax Act of 2016 (Proposition 56, an initiative measure approved
10 at the November 8, 2016, statewide general election) that were
11 implemented with funds from the Healthcare Treatment Fund, as
12 established pursuant to subdivision (a) of Section 30130.55 of the
13 Revenue and Taxation Code, in effect as of December 31, 2023,
14 as determined by the department:

15 (A) Primary care services, including those provided by
16 physicians or nonphysician health professionals, as defined in
17 Section 51170.5 of Title 22 of the California Code of Regulations.

18 (B) Obstetric care services, and doula services as described in
19 Section 14132.24.

20 (C) Outpatient mental health services that are not the financial
21 responsibility of county mental health plans operating pursuant to
22 Chapter 8.9 (commencing with Section 14700).

23 (2) The department shall annually review and revise the
24 reimbursement rates in accordance with paragraph (1) based on
25 changes to the lowest maximum allowance established by the
26 federal Medicare Program for the same or similar services. Any
27 revisions to the reimbursement rates determined in accordance
28 with paragraph (1) shall be considered as part of the annual budget
29 development process and take effect beginning on January 1, 2025,
30 and each subsequent January 1 thereafter, of the calendar year
31 following the department's annual review.

32 (3) The department shall develop and implement a methodology
33 for establishing reimbursement rates or payments for the services
34 described in paragraph (1) where there is no specified maximum
35 allowable rate established by the federal Medicare Program. The
36 department shall review this methodology annually and may, in
37 its sole discretion, modify the methodology on a prospective basis.

38 (b) (1) (A) For contract periods during which subdivision (a)
39 is implemented, each Medi-Cal managed care plan shall reimburse
40 a network provider furnishing the services subject to subdivision

1 (a) at least the amount the network provider would be paid for
2 those services in the Medi-Cal fee-for-service delivery system, as
3 set forth by the department in the approved Medi-Cal State Plan
4 and guidance issued pursuant to subdivision ~~(e)~~. (f).

5 (B) Medi-Cal managed care plans that reimburse a network
6 provider furnishing the services identified in subparagraphs (A)
7 to (C), inclusive, of paragraph (1) of subdivision (a) on a capitated
8 basis shall ensure that the network provider receives reimbursement
9 that is equal to, or projected to be equal to, the level of
10 reimbursement required in subparagraph (A) for the applicable
11 services and, as applicable, shall increase reimbursement to the
12 network provider to comply with this subparagraph.

13 (2) The department may require Medi-Cal managed care plans
14 and network providers of the applicable services to submit
15 information the department deems necessary to implement and
16 monitor compliance with this subdivision, at the times and in the
17 form and manner specified by the department.

18 (c) (1) The payments implemented pursuant to subdivisions (a)
19 and (b) shall be supported by the managed care organization
20 provider tax revenue, pursuant to Article 7.1 (commencing with
21 Section 14199.80), or other state funds appropriated to the
22 department as the state share for this purpose, including, but not
23 limited to, funds transferred to the Medi-Cal Provider Payment
24 Reserve Fund in accordance with Sections 14105.200 and 14199.82
25 and to the Healthcare Treatment Fund in accordance with
26 subdivision (a) of Section 30130.55 of the Revenue and Taxation
27 Code.

28 (2) Notwithstanding any other law, increases to fee-for-service
29 reimbursement rates and managed care directed payments that are
30 made pursuant to subdivisions (a) and (b) constitute increases in
31 accordance with subdivision (a) of Section 30130.55 of the
32 Revenue and Taxation Code, and all other fee-for-service
33 supplemental payments and managed care directed payments for
34 the services identified in subparagraphs (A) to (C), inclusive, of
35 paragraph (1) of subdivision (a) that are made pursuant to
36 subdivision (a) of Section 30130.55 of the Revenue and Taxation
37 Code shall be discontinued on the date the payments implemented
38 pursuant to subdivisions (a) and (b) are effective.

1 (d) (1) *Effective for dates of service on or after January 1, 2025,*
2 *community health workers shall be an eligible provider type for*
3 *the rate increases effective pursuant to this section.*

4 (2) *In establishing the reimbursement rate for community health*
5 *workers pursuant to subdivision (a), the department shall set rates*
6 *equal to 100 percent of the lowest maximum allowance established*
7 *by the federal Medicare Program for the same or similar services.*

8 (3) *If the voters approve the addition of Chapter 7.5*
9 *(commencing with Section 14199.100) to this part at the November*
10 *5, 2024, statewide general election, this subdivision shall be*
11 *inoperative as of January 1, 2025.*

12 ~~(d)~~

13 (e) *In implementing this section, the department shall seek any*
14 *federal approvals that it deems necessary. This section shall be*
15 *implemented only to the extent that any necessary federal approvals*
16 *are obtained and federal financial participation is available and is*
17 *not otherwise jeopardized.*

18 ~~(e)~~

19 (f) *Notwithstanding the rulemaking provisions of Chapter 3.5*
20 *(commencing with Section 11340) of Part 1 of Division 3 of Title*
21 *2 of the Government Code, the department may implement this*
22 *section, in whole or in part, by means of all-county letters, plan*
23 *letters, provider bulletins, information notices, or other similar*
24 *instructions, without taking any further regulatory action.*

25 ~~(f)~~

26 (g) *The department shall develop the methodologies and*
27 *parameters for the payments implemented pursuant to subdivisions*
28 ~~(a) and (b);~~ *(a), (b), and (d), and may revise the methodologies*
29 *and parameters, for purposes including, but not limited to, obtaining*
30 *or maintaining any necessary federal approvals as required by*
31 *subdivision ~~(d)~~; (e).*

32 ~~(g)~~

33 (h) *For purposes of this section, the following definitions shall*
34 *apply:*

35 (1) *“Community health workers” has the same meaning as set*
36 *forth in the Medi-Cal State Plan.*

37 ~~(1)~~

38 (2) *“Medi-Cal managed care plan” has the same meaning as*
39 *that term is defined in subdivision (j) of Section 14184.101.*

40 ~~(2)~~

1 (3) “Network provider” has the same meaning as that term is
2 defined in Section 438.2 of Title 42 of the Code of Federal
3 Regulations.

4 (h)

5 (i) The Legislature finds and declares that this section, as it
6 pertains to funding made available for expenditure pursuant to
7 subdivision (a) of Section 30130.55 of the Revenue and Taxation
8 Code, is consistent and in accordance with the California
9 Healthcare, Research and Prevention Tobacco Tax Act of 2016
10 (Proposition 56, an initiative measure approved at the November
11 8, 2016, statewide general election).

12 *SEC. 59. Section 14105.202 of the Welfare and Institutions*
13 *Code is repealed.*

14 ~~14105.202. (a) The department shall submit to the Legislature,~~
15 ~~as part of the 2024–25 Governor’s Budget, a plan for targeted~~
16 ~~increases to Medi-Cal payments or other investments as described~~
17 ~~in subdivision (c) of Section 14105.200. The targeted increases or~~
18 ~~other investments shall be designed to advance access, quality,~~
19 ~~and equity for Medi-Cal beneficiaries and promote provider~~
20 ~~participation in the Medi-Cal program in the following domains,~~
21 ~~pursuant to criteria established by the department, which may~~
22 ~~account for, and be inclusive of, the exemption of applicable~~
23 ~~services from payment reductions pursuant to Section 14105.192:~~

24 ~~(1) (A) Primary care services, including those provided by~~
25 ~~physicians or nonphysician health professionals, as defined in~~
26 ~~Section 51170.5 of Title 22 of the California Code of Regulations.~~

27 ~~(B) Obstetric care services, and doula services as described in~~
28 ~~Section 14132.24.~~

29 ~~(C) Outpatient mental health services that are not the financial~~
30 ~~responsibility of county mental health plans operating pursuant to~~
31 ~~Chapter 8.9 (commencing with Section 14700).~~

32 ~~(2) Specialty care services.~~

33 ~~(3) Community or hospital outpatient procedures and services.~~

34 ~~(4) Family planning services and women’s health providers.~~

35 ~~(5) Hospital-based emergency and emergency physician~~
36 ~~services.~~

37 ~~(6) Ground emergency transport services.~~

38 ~~(7) Designated public hospitals, as defined in subdivision (f) of~~
39 ~~Section 14184.101.~~

1 ~~(8) Behavioral health care for beneficiaries in hospital and~~
2 ~~institutional long-term care settings.~~

3 ~~(9) Investments to maintain and grow the health care workforce.~~

4 ~~(b) (1) The payments implemented pursuant to subdivision (a)~~
5 ~~shall be supported by the managed care organization provider tax~~
6 ~~revenue, pursuant to Article 7.1 (commencing with Section~~
7 ~~14199.80), or other state funds appropriated to the department as~~
8 ~~the state share for this purpose, including, but not limited to, funds~~
9 ~~transferred to the Medi-Cal Provider Payment Reserve Fund in~~
10 ~~accordance with Sections 14105.200 and 14199.82 and, for~~
11 ~~applicable services as determined by the department, to the~~
12 ~~Healthcare Treatment Fund in accordance with subdivision (a) of~~
13 ~~Section 30130.55 of the Revenue and Taxation Code.~~

14 ~~(2) Notwithstanding any other law, increases to fee-for-service~~
15 ~~reimbursement rates and managed care directed payments that are~~
16 ~~made pursuant to subdivision (a) constitute increases in accordance~~
17 ~~with subdivision (a) of Section 30130.55 of the Revenue and~~
18 ~~Taxation Code, and all other fee-for-service supplemental payments~~
19 ~~and managed care directed payments for services identified in~~
20 ~~subdivision (a), as applicable, that are made pursuant to subdivision~~
21 ~~(a) of Section 30130.55 of the Revenue and Taxation Code shall~~
22 ~~be discontinued on the date the payments implemented pursuant~~
23 ~~to subdivisions (a) are effective.~~

24 *SEC. 60. Section 14105.467 of the Welfare and Institutions*
25 *Code is amended to read:*

26 14105.467. (a) The department shall establish, implement,
27 and maintain a supplemental payment pool for nonhospital 340B
28 community clinics, subject to an appropriation by the Legislature.

29 (b) Beginning January 1, 2021, and any subsequent fiscal year
30 to the extent funds are appropriated by the Legislature for the
31 purpose described in this section, the department shall make
32 available fee-for-service-based supplemental payments from a
33 fixed-amount payment pool to qualifying nonhospital 340B
34 community clinics in accordance with this section and any terms
35 of federal approval obtained pursuant to subdivision (f).

36 (c) (1) On or before July 15, 2020, the department shall establish
37 a stakeholder process, which shall include representatives of
38 qualifying nonhospital 340B community clinics. Representatives
39 shall be geographically diverse and consist of qualifying
40 nonhospital 340B community clinics with differing pharmacy

1 arrangements, including those that operate in-house pharmacies
2 and those with contract pharmacy arrangements. The stakeholder
3 process shall be utilized to develop and implement the methodology
4 for distribution of supplemental pool payments to qualifying
5 nonhospital 340B community clinics. This shall include the
6 eligibility criteria for receipt of supplemental payments, the
7 aggregate amount of pool funding available in a respective fiscal
8 year, the criteria for apportioning the pool funding among
9 qualifying nonhospital 340B community clinics, and the timing,
10 frequency, and amount of the resultant supplemental payments.

11 (2) The department shall conduct at least three meetings with
12 stakeholders and shall finalize the methodology for distribution
13 no later than October 1, 2020.

14 (d) (1) For any fiscal year that the department implements this
15 section, the aggregate amount of supplemental payments available
16 shall not exceed the pool amount established by the department
17 for the respective fiscal year pursuant to subdivision (b).

18 (2) For any fiscal year that the department implements this
19 section, the supplemental payment amounts received by a
20 qualifying nonhospital 340B community clinic shall not exceed
21 the apportioned amounts of the pool funding attributable to that
22 individual clinic under the methodology developed pursuant to
23 subdivision (c).

24 (e) To the extent permissible under federal law, supplemental
25 payments received by qualifying nonhospital 340B community
26 clinics pursuant to this section shall be considered separate and
27 apart from the prospective payment system (PPS) reimbursement
28 the clinic receives pursuant to Section 1396a(bb) of Title 42 of the
29 United States Code and shall not be considered during annual
30 reconciliation of the PPS rate.

31 (f) (1) The department may modify any methodology or other
32 requirement specified in this section to the extent it deems
33 necessary to meet the requirements of federal law or regulations,
34 to obtain or maintain federal approval, or to ensure federal financial
35 participation is available or not otherwise jeopardized.

36 (2) If the department determines that a modification is necessary
37 pursuant to paragraph (1), the department shall consult with
38 participants of the stakeholder process established pursuant to
39 subdivision (c) to the extent practicable.

1 (3) If a modification is made, the department shall notify
2 qualifying nonhospital 340B community clinics, the Joint
3 Legislative Budget Committee, and the relevant policy and fiscal
4 committees of the Legislature within 10 business days of that
5 modification.

6 (g) The department shall implement this section only to the
7 extent that any necessary federal approvals have been obtained,
8 and federal financial participation is available and is not otherwise
9 jeopardized.

10 (h) Notwithstanding Chapter 3.5 (commencing with section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 the department may implement, interpret, or make specific this
13 section, in whole or in part, by means of provider bulletins or other
14 similar instructions, without taking any further regulatory action.

15 (i) For purposes of this section:

16 (1) “340B” means the discount drug purchasing program
17 described in Section 256b of Title 42 of the United States Code.

18 (2) “Qualifying nonhospital 340B community clinic” means a
19 center or clinic that is licensed under subdivision (a) of Section
20 1204 of the Health and Safety Code, or a clinic operated by a city,
21 county, city and county, or hospital authority that is exempt from
22 licensure under subdivision (b) of Section 1206 of the Health and
23 Safety Code, and that is a 340B covered entity pursuant to Section
24 256b of Title 42 of the United States Code for the duration of each
25 applicable fiscal year for which the department implements this
26 section.

27 (j) *Upon implementation of Section 14105.468 and the*
28 *completion of all closeout activities associated with this section,*
29 *the director shall execute a declaration, which shall be retained*
30 *by the director, stating that implementation of Section 14105.468*
31 *has commenced and that all closeout activities associated with*
32 *this section have been completed. This section shall become*
33 *inoperative one year after the date that the director executes the*
34 *declaration and shall be repealed on January 1 of the year*
35 *following the date upon which this section becomes inoperative.*

36 *SEC. 61. Section 14105.468 is added to the Welfare and*
37 *Institutions Code, to read:*

38 *14105.468. (a) (1) Beginning for dates of service on or after*
39 *January 1, 2025, the department shall establish and implement a*
40 *directed payment program under which a qualifying nonhospital*

1 340B community clinic may earn payments from contracted
2 Medi-Cal managed care plans, subject to an appropriation by the
3 Legislature.

4 (2) (A) Beginning for dates of service on or after January 1,
5 2026, the department shall increase the amount of directed
6 payments pursuant to paragraph (1) with amounts allocated from
7 the Medi-Cal Provider Payment Reserve Fund in accordance with
8 Section 14105.200.

9 (B) If the voters approve the addition of Chapter 7.5
10 (commencing with Section 14199.100) to this part at the November
11 5, 2024, statewide general election, this paragraph shall be
12 inoperative as of January 1, 2025.

13 (b) The department, in consultation with affected stakeholders,
14 and affected Medi-Cal managed care plans, as applicable, shall
15 establish the methodology or methodologies, parameters, and
16 eligibility criteria for the directed payments pursuant to this
17 section. This shall include, but is not limited to, the milestones and
18 metrics that a qualifying nonhospital 340B community clinic shall
19 meet in order to receive a directed payment from a Medi-Cal
20 managed care plan pursuant to this section. The department may
21 implement the directed payment described in this subdivision using
22 one or more of the models authorized by subsection (c) of Section
23 438.6 of Title 42 of the Code of Federal Regulations.

24 (c) To the extent permissible under federal law, directed
25 payments received by qualifying nonhospital 340B community
26 clinics pursuant to this section shall be considered separate and
27 apart from the prospective payment system (PPS) reimbursement
28 the clinic receives pursuant to subsection (bb) of Section 1396a
29 of Title 42 of the United States Code and shall not be considered
30 during annual reconciliation of the PPS rate.

31 (d) Notwithstanding Chapter 3.5 (commencing with Section
32 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
33 the department may implement, interpret, or make specific this
34 section in whole or in part, by means of all-county letters, plan
35 letters, provider bulletins, information notices, or other similar
36 instructions, without taking any further regulatory action.

37 (e) The department shall seek any federal approvals it deems
38 necessary to implement this section. This section shall be
39 implemented only to the extent that any necessary federal approvals

1 are obtained and federal financial participation is available and
2 is not otherwise jeopardized.

3 (f) For any calendar year in which this section is implemented,
4 in whole or in part, and notwithstanding any other law, neither
5 the department nor a Medi-Cal managed care plan shall be
6 required to make the payments specified in Section 14105.467.

7 (g) For purposes of this section:

8 (1) “340B” means the discount drug purchasing program
9 described in Section 256b of Title 42 of the United States Code.

10 (2) “Qualifying nonhospital 340B community clinic” means a
11 center or clinic that is licensed under subdivision (a) of Section
12 1204 of the Health and Safety Code, or a clinic operated by a city,
13 county, city and county, or hospital authority that is exempt from
14 licensure under subdivision (b) of Section 1206 of the Health and
15 Safety Code, and that is a 340B covered entity pursuant to Section
16 256b of Title 42 of the United States Code for the duration of each
17 applicable fiscal year for which the department implements this
18 section.

19 SEC. 62. Section 14124.12 of the Welfare and Institutions Code
20 is amended to read:

21 14124.12. (a) (1) Notwithstanding any other law, for the
22 duration of the COVID-19 emergency period, the department shall
23 implement any federal Medicaid program waiver or flexibility
24 approved by the federal Centers for Medicare and Medicaid
25 Services related to the COVID-19 public health emergency. This
26 includes, but is not limited to, any waiver or flexibility approved
27 pursuant to Sections 1315, 1320b-5, or 1396n of Title 42 of the
28 United States Code, or the Medi-Cal state plan. Any request for a
29 federal Medicaid program waiver or flexibility shall be subject to
30 Department of Finance approval before the department submits
31 that request to the federal Centers for Medicare and Medicaid
32 Services.

33 (2) During the COVID-19 emergency period, and through
34 December 31, 2022, for any extended waiver or flexibility
35 described in subdivision (f), if there is a conflict between this
36 chapter, Chapter 8 (commencing with Section 14200), Chapter
37 8.8 (commencing with Section 14600), or Chapter 8.9
38 (commencing with Section 14700), and any approved federal
39 waiver or flexibility, as described in paragraph (1), the approved

1 federal waiver or flexibility shall control over any conflict in the
2 specified state law.

3 (b) (1) To the extent that federal financial participation is
4 available, the department, subject to Department of Finance
5 approval, shall exercise its option under Section
6 1396a(a)(10)(A)(ii)(XXIII) of Title 42 of the United States Code
7 to extend the medical assistance, as described in Section
8 1396a(a)(10)(A)(ii)(XVIII) of Title 42 of the United States Code,
9 to uninsured individuals, as defined in Section 1396a(ss) of Title
10 42 of the United States Code, for the duration of the COVID-19
11 emergency period.

12 (2) The department, subject to Department of Finance approval,
13 may seek federal approval pursuant to Section 1315 of Title 42 of
14 the United States Code to extend the medical assistance afforded
15 to uninsured individuals pursuant to paragraph (1) to include
16 COVID-19-related treatment services that are otherwise covered
17 for full-scope Medi-Cal beneficiaries, as defined by the department.
18 If federal financial participation is unavailable, the department,
19 subject to Department of Finance approval, may elect to implement
20 this paragraph on a state-only funding basis, and subject to an
21 appropriation by the Legislature.

22 (c) Notwithstanding any other law, the department shall seek
23 to maximize federal financial participation for Medi-Cal
24 expenditures that it determines to be available for the COVID-19
25 public health emergency, and shall comply with any federal
26 requirements and conditions for receipt of that federal financial
27 participation. This includes, but is not limited to, the temporary
28 increase in the federal medical assistance percentage made
29 available pursuant to Section 6008 of the federal Families First
30 Coronavirus Response Act (Public Law 116-127).

31 (d) Due to the impact of the COVID-19 public health emergency
32 on the department's ongoing administration of the Medi-Cal
33 program, the department may seek any federal approvals it deems
34 necessary for any number of temporary extensions of all or select
35 components of the California Medi-Cal 2020 Demonstration (No.
36 11-W-00193/9) pursuant to Article 5.5 (commencing with Section
37 14184), which is scheduled to expire on December 31, 2020. If
38 the department elects to seek any extension, the department shall
39 determine the length of time for the extension sought and whether
40 to seek an extension for the entirety of the demonstration or select

1 components of the demonstration. In implementing this
2 subdivision, the department, to the extent practicable, shall consult
3 with affected stakeholder entities before seeking a temporary
4 extension.

5 (e) The department, subject to Department of Finance approval,
6 shall seek any federal approvals it deems necessary to implement
7 this section or to maintain sufficient access to covered benefits
8 under the Medi-Cal program during the COVID-19 emergency
9 period. This section shall be implemented only to the extent that
10 any necessary federal approvals are obtained and federal financial
11 participation is available and is not otherwise jeopardized.

12 (f) (1) (A) The department shall seek any federal approvals it
13 deems necessary to extend the approved waiver or flexibility
14 implemented pursuant to subdivision (a), as of July 1, 2021, that
15 are related to the delivery and reimbursement of services via
16 telehealth modalities in the Medi-Cal program. Subject to
17 subdivision (e), the department shall implement those extended
18 waivers or flexibilities for which federal approval is obtained, to
19 commence on the first calendar day immediately following the
20 last calendar day of the federal COVID-19 public health emergency
21 period, and through December 31, 2022.

22 (B) Subject to subdivision (e), the department may authorize
23 the use of remote patient monitoring as an allowable telehealth
24 modality for covered health care services and provider types it
25 deems appropriate for dates of service on or after July 1, 2021.
26 The department may establish a fee schedule for applicable health
27 care services delivered via remote patient monitoring.

28 (2) (A) For purposes of informing the 2022–23 proposed
29 Governor’s Budget, released in January 2022, the department shall
30 convene an advisory group consisting of consultants, subject matter
31 experts, and other affected stakeholders to provide
32 recommendations to inform the department in establishing and
33 adopting billing and utilization management protocols for telehealth
34 modalities to increase access and equity and reduce disparities in
35 the Medi-Cal program. The advisory group shall analyze the impact
36 of telehealth in increased access for patients, changes in health
37 quality outcomes and utilization, best practices for the appropriate
38 mix of in-person visits and telehealth, and the benefits or liabilities
39 of any practice or care model changes that have resulted from
40 telephonic visits.

1 (B) The advisory group shall include representatives of the
2 California Medical Association, the California Primary Care
3 Association, the California Association of Public Hospitals, the
4 County Behavioral Health Directors Association, Medi-Cal
5 managed care plans, Planned Parenthood Affiliates of California,
6 Essential Access Health, and other subject matter experts or other
7 affected stakeholders as identified by the department.

8 (3) For purposes of implementing this subdivision, the
9 department may enter into exclusive or nonexclusive contracts, or
10 amend existing contracts, on a bid or negotiated basis. Contracts
11 entered into or amended pursuant to this paragraph shall be exempt
12 from Chapter 6 (commencing with Section 14825) of Part 5.5 of
13 Division 3 of Title 2 of the Government Code, Section 19130 of
14 the Government Code, Part 2 (commencing with Section 10100)
15 of Division 2 of the Public Contract Code, and the State
16 Administrative Manual, and shall be exempt from the review or
17 approval of any division of the Department of General Services.

18 (4) Nothing in this subdivision shall be construed to limit
19 coverage of, and reimbursement for, telehealth modalities that are
20 the type authorized by the department prior to the COVID-19
21 emergency period and described in the Medi-Cal State Plan, the
22 Medi-Cal provider manual, or other departmental guidance.

23 (g) (1) Notwithstanding any other law, subject to appropriation
24 by the Legislature and Section 11.95 of the Budget Act of 2021,
25 the department shall implement those activities and expenditures
26 to enhance, expand, or strengthen home and community-based
27 services (HCBS) under the Medi-Cal program that are approved
28 by the federal Centers for Medicare and Medicaid Services pursuant
29 to Section 9817 of the federal American Rescue Plan Act of 2021
30 (Public Law 117-2) and associated federal guidance.

31 (2) Notwithstanding any other law, the department shall comply
32 with any federal requirements and conditions as necessary to claim
33 the increased federal medical assistance percentage for eligible
34 HCBS expenditures pursuant to Section 9817 of the federal
35 American Rescue Plan Act of 2021 (Public Law 117-2) and
36 associated federal guidance.

37 (3) Notwithstanding any other law, stipends or payments
38 received by an individual from initiatives included in the approved
39 HCBS spending plan described in this subdivision shall not be
40 considered income or resources for purposes of determining the

1 individual's, or any member of their household's, eligibility for
2 benefits or assistance, or the amount or extent of benefits or
3 assistance, under any state or local benefit or assistance program,
4 to the extent permitted under federal law and, where applicable,
5 to the extent any necessary federal approvals are obtained.

6 (4) Notwithstanding Chapter 3.5 (commencing with Section
7 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
8 the department, the State Department of Social Services, the
9 California Department of Aging, the State Department of Public
10 Health, the State Department of Developmental Services, the State
11 Department of Rehabilitation, and the Department of Health Care
12 Access and Information, as applicable, may implement, interpret,
13 or make specific this subdivision and any HCBS activity described
14 in paragraph (1) by means of all-county letters, plan letters,
15 provider bulletins, or other similar instructions, without taking any
16 further regulatory action.

17 (5) For purposes of implementing this subdivision and any
18 HCBS activity described in paragraph (1), the department, the
19 State Department of Social Services, the California Department
20 of Aging, the State Department of Public Health, the State
21 Department of Developmental Services, the State Department of
22 Rehabilitation, and the Department of Health Care Access and
23 Information, as applicable, may enter into exclusive or
24 nonexclusive contracts, or amend existing contracts, on a bid or
25 negotiated basis. Contracts entered into or amended pursuant to
26 this paragraph, and the implementation of any HCBS activity
27 described in paragraph (1), shall be exempt from Chapter 6
28 (commencing with Section 14825) of Part 5.5 of Division 3 of
29 Title 2 of the Government Code, Section 19130 of the Government
30 Code, Part 2 (commencing with Section 10100) of Division 2 of
31 the Public Contract Code, Chapters 7 (commencing with Section
32 9530) and 7.5 (commencing with Section 9540) of Division 8.5
33 of this code, and the State Administrative Manual, and shall be
34 exempt from the review or approval of any division of the
35 Department of General Services.

36 (6) Any funding made available to the Traumatic Brain Injury
37 Program in the State Department of Rehabilitation pursuant to
38 paragraph (1) shall be exempted from subdivision (b) of Section
39 4355, subdivision (b) of Section 4357, and subdivision (c) of
40 Section 4357.1.

1 (h) Notwithstanding any other law, ~~upon expiration of the~~
 2 ~~COVID-19 emergency period and~~ subject to subdivision (e), the
 3 department shall ~~continue to reimburse the administration of a~~
 4 ~~COVID-19 vaccine at 100 percent of the Medicare national~~
 5 ~~equivalent rates in effect at the time the vaccine is administered~~
 6 ~~and without any geographic adjustment.~~ *align COVID-19 vaccine*
 7 *administration payments to payment reimbursement structures for*
 8 *vaccines administered in accordance with the Medi-Cal State Plan.*

9 (i) Notwithstanding Chapter 3.5 (commencing with Section
 10 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
 11 the department may implement, interpret, or make specific this
 12 section by means of all-county letters, plan letters, provider
 13 bulletins, or other similar instructions without taking any further
 14 regulatory action.

15 (j) For purposes of this section, the following definitions apply:

16 (1) “COVID-19 emergency period” has the same meaning as
 17 “emergency period” as defined in Section 1320b-5(g)(1)(B) of
 18 Title 42 of the United States Code, unless otherwise defined in
 19 federal law or any federal approval obtained pursuant to this
 20 section.

21 (2) “COVID-19 public health emergency” means the Public
 22 Health Emergency declared by the Secretary of the United States
 23 Department of Health and Human Services on January 31, 2020,
 24 pursuant to Section 247d of Title 42 of the United States Code,
 25 and entitled “Determination that a Public Health Emergency Exists
 26 Nationwide as the Result of the 2019 Novel Coronavirus,”
 27 including any subsequent renewal of that declaration.

28 *SEC. 63. Article 3.1 (commencing with Section 14124.160) is*
 29 *added to Chapter 7 of Part 3 of Division 9 of the Welfare and*
 30 *Institutions Code, to read:*

31
 32 *Article 3.1. Medi-Cal Provider Payment Increases and*
 33 *Investments Act*
 34

35 *14124.160. (a) This article shall be known, and may be cited,*
 36 *as the Medi-Cal Provider Payment Increases and Investments*
 37 *(PPI) Act.*

38 *(b) The implementation of the act, as set forth in this article and*
 39 *the PPI Terms and Conditions, shall support all of the following*
 40 *goals:*

1 (1) *Improve access to high-quality care for Medi-Cal members,*
2 *especially in underserved areas.*

3 (2) *Promote provider participation in the Medi-Cal program.*

4 (3) *Strengthen the Medi-Cal program’s foundation through*
5 *reimbursement methodologies that are more competitive with other*
6 *payors and, where applicable, allow for periodic adjustments to*
7 *keep pace with health care cost inflation.*

8 *14124.161. For purposes of this article, and elsewhere in law*
9 *where specified, the following definitions shall apply:*

10 (a) *“PPI” means the respective components of the Medi-Cal*
11 *Provider Payment Increases and Investments Act authorized by*
12 *this article or other sections of law amended by the act that added*
13 *this subdivision, and, as applicable, approved by the federal*
14 *Centers for Medicare and Medicaid Services in the PPI Terms*
15 *and Conditions.*

16 (b) *“PPI Terms and Conditions” means those terms and*
17 *conditions issued and approved by the federal Centers for*
18 *Medicare and Medicaid Services, including any attachments,*
19 *appendices, or similar documents, and subsequent amendments*
20 *thereto, that govern implementation of the respective components*
21 *of PPI pursuant to this article or other sections of law amended*
22 *by the act that added this subdivision. PPI Terms and Conditions*
23 *shall include, at a minimum, any terms and conditions specified*
24 *in the following:*

25 (1) *Any Medi-Cal Demonstration approved by the federal*
26 *Centers for Medicare and Medicaid Services pursuant to Section*
27 *1315 of Title 42 of the United States Code that are necessary to*
28 *implement a PPI component.*

29 (2) *Any Medicaid Waivers as approved by the federal Centers*
30 *for Medicare and Medicaid Services pursuant to Section 1396n*
31 *of Title 42 of the United States Code that are necessary to*
32 *implement a PPI component.*

33 (3) *Any associated Medi-Cal State Plan amendments approved*
34 *by the federal Centers for Medicare and Medicaid Services that*
35 *are necessary to implement a PPI component.*

36 (4) *Any provision of a comprehensive risk contract, nonrisk*
37 *contract, or other similar managed care arrangement, including*
38 *an intergovernmental agreement or directed payment authorized*
39 *pursuant to Section 438.6(c) of Title 42 of the Code of Federal*
40 *Regulations, approved by the federal Centers for Medicare and*

1 *Medicaid Services to implement this article, or the authorities*
2 *described in paragraph (1), (2), or (3).*

3 *(c) “Abortion services” has the same meaning as set forth in*
4 *subdivision (a) of Section 123464 of the Health and Safety Code.*

5 *(d) “Comprehensive risk contract” has the same meaning as*
6 *set forth in Section 438.2 of Title 42 of the Code of Federal*
7 *Regulations.*

8 *(e) “Medi-Cal managed care plan” means any individual,*
9 *organization, or entity that enters into a comprehensive risk*
10 *contract with the department to provide covered full-scope health*
11 *care services to enrolled Medi-Cal beneficiaries pursuant to any*
12 *provision of this chapter or Chapter 8 (commencing with Section*
13 *14200).*

14 *(f) “Network provider” has the same meaning as set forth in*
15 *Section 438.2 of Title 42 of the Code of Federal Regulations.*

16 *(g) “Nonrisk contract” has the same meaning as set forth in*
17 *Section 438.2 of Title 42 of the Code of Federal Regulations.*

18 *14124.162. (a) Consistent with federal law, the department*
19 *shall seek federal approval for, and implement PPI, including, but*
20 *not limited to, all of the following components:*

21 *(1) Reimbursement increases for professional services described*
22 *in Section 14124.163.*

23 *(2) Reimbursement increases for ground emergency medical*
24 *transport services described in Section 14124.164.*

25 *(3) Reimbursement increases for abortion services described*
26 *in Section 14124.165.*

27 *(4) Reimbursement increases for family planning services*
28 *described in Section 14124.166.*

29 *(5) Reimbursement increases for services described in Section*
30 *14124.167.*

31 *(6) Updating the reimbursement methodology for optional*
32 *hearing aid benefits, as described in Section 14131.05.*

33 *(7) Elimination of certain rate reductions as described in*
34 *paragraph (16) of subdivision (h) of Section 14105.192.*

35 *(8) Implementation of increases to the amount of directed*
36 *payments for qualifying nonhospital 340B community clinics*
37 *pursuant to paragraph (2) of subdivision (a) of Section 14105.468.*

38 *(b) Notwithstanding Chapter 3.5 (commencing with Section*
39 *11340) of Part 1 of Division 3 of Title 2 of the Government Code,*
40 *the department may implement, interpret, or make specific this*

1 article, other sections of law amended by the act that added this
2 subdivision, the PPI Terms and Conditions, or any appertaining
3 Medi-Cal reimbursement methodologies in whole or in part, by
4 means of all-county letters, plan letters, provider bulletins,
5 information notices, or other similar instructions, without taking
6 any further regulatory action.

7 (c) For purposes of implementing this article, other sections of
8 law amended by the act that added this subdivision, or the PPI
9 Terms and Conditions, the department may enter into exclusive
10 or nonexclusive contracts, or amend existing contracts, on a bid
11 or negotiated basis, and may implement changes to existing
12 information technology systems. Notwithstanding any other law,
13 contracts entered into or amended, or changes to existing
14 information technology systems, pursuant to this subdivision shall
15 be exempt from Chapter 6 (commencing with Section 14825) of
16 Part 5.5 of Division 3 of Title 2 of the Government Code, Section
17 19130 of the Government Code, and Part 2 (commencing with
18 Section 10100) of Division 2 of the Public Contract Code, and
19 shall be exempt from the review or approval of any division of the
20 Department of General Services.

21 (d) The department shall seek any federal approvals it deems
22 necessary to implement PPI under this article and other provisions
23 of law amended by the act that added this subdivision. This shall
24 include, but need not be limited to, approval of any amendment,
25 addition, or technical correction to the PPI Terms and Conditions,
26 as the department deems necessary. Except those portions of this
27 article related to abortion services, this article shall be
28 implemented only to the extent that any necessary federal approvals
29 are obtained and federal financial participation is available and
30 is not otherwise jeopardized.

31 (e) To the extent that there is a later enacted statute that restricts
32 the availability of the moneys in, restricts transfers of moneys into,
33 or transfers moneys out of the Medi-Cal Provider Payment Reserve
34 Fund, or restricts the availability or use of managed care
35 organization provider tax revenues derived from the taxes imposed
36 pursuant to Article 7.1 (commencing with Section 14199.80) or
37 any subsequent continuation of the managed care organization
38 provider tax, the department shall only implement this article or
39 other sections of law amended by the act that added this section
40 to the extent that the department determines the provisions of this

1 article remain feasible with or without making modifications
2 pursuant to subdivision (f).

3 (f) (1) Consistent with subdivisions (d) and (e), the director may
4 modify any methodology or parameter specified in this article or
5 other sections of law amended by the act that added this
6 subdivision, to the extent necessary to do any of the following:

7 (A) To comply with federal law or the PPI Terms and
8 Conditions, to obtain or maintain federal approval, or to ensure
9 federal financial participation is available and not otherwise
10 jeopardized.

11 (B) To conform with any later enacted statute that restricts the
12 availability of the moneys in, restricts transfers of moneys into, or
13 transfers moneys out of the Medi-Cal Provider Payment Reserve
14 Fund, or restricts the availability or use of managed care
15 organization provider tax revenues derived from the taxes imposed
16 pursuant to Article 7.1 (commencing with Section 14199.80) or
17 any subsequent continuation of the managed care organization
18 provider tax.

19 (2) Any modification must be consistent with the goals set forth
20 in this article and its individual components. Modifications may
21 include, but are not limited to, implementing PPI components on
22 a time-limited basis or modifying the targeted funding amounts or
23 applicable percentages without exceeding amounts appropriated
24 in the state budget for these purposes.

25 (3) Prior to proposing a modification pursuant to this
26 subdivision, the director shall consult with affected stakeholders.
27 Upon approval by the Department of Finance, any modification
28 made pursuant to this subdivision shall take effect no sooner than
29 30 days after the director provides public notice of the proposed
30 modification and provides notification to the chairpersons of the
31 committees in each house of the Legislature that consider health
32 policy, chairpersons of the committees in each house of the
33 Legislature that consider appropriations, the chairpersons of the
34 committees and appropriate subcommittees that consider the State
35 Budget, and the Chairperson of the Joint Legislative Budget
36 Committee, or not sooner than whatever lesser time the chairperson
37 of the joint committee, or the chairperson's designee, may
38 determine. The public notice shall include a description of the
39 projected fiscal impact of the proposed modification on each PPI
40 component. Submission of the semiannual Medi-Cal estimate

1 *provided to the Legislature in January and May shall be considered*
2 *meeting the notification requirement of this provision if the*
3 *required information is included in the estimate.*

4 *(g) The payment methodologies, investments, and parameters*
5 *developed and implemented pursuant to this article, the PPI Terms*
6 *and Conditions, or other sections of law amended by the act that*
7 *added this subdivision shall supersede any conflicting law or*
8 *regulation, shall, as applicable, supersede and replace any other*
9 *applicable payment methodology, and shall be implemented*
10 *notwithstanding any other law.*

11 *(h) (1) The payments implemented pursuant to this article, other*
12 *sections of law amended by the act that added this subdivision, or*
13 *the PPI Terms and Conditions shall be supported by managed*
14 *care organization provider tax revenue, either pursuant to Article*
15 *7.1 (commencing with Section 14199.80) or any subsequent*
16 *continuation of the managed care organization provider tax, or*
17 *other state funds appropriated by the Legislature to the department*
18 *as the state's share for this purpose, including, but not limited to,*
19 *funds transferred to the Medi-Cal Provider Payment Reserve Fund*
20 *in accordance with Sections 14105.200 and 14199.82, and to the*
21 *Healthcare Treatment Fund in accordance with subdivision (a) of*
22 *Section 30130.55 of the Revenue and Taxation Code.*

23 *(2) Notwithstanding any other law, the Legislature finds and*
24 *declares increases to fee-for-service reimbursement rates and*
25 *managed care capitation payments that are made pursuant to this*
26 *article, other sections of law amended by the act that added this*
27 *subdivision, or the PPI Terms and Conditions constitute increases*
28 *in accordance with subdivision (a) of Section 30130.55 of the*
29 *Revenue and Taxation Code.*

30 *(3) Notwithstanding any other law, increases to fee-for-service*
31 *reimbursement rates, managed care capitation payments, or other*
32 *investments that are made pursuant to this article, other sections*
33 *of law amended by the act that added this section, or the PPI Terms*
34 *and Conditions constitute increased reimbursement rates in*
35 *accordance with statutory requirements imposed on the use of*
36 *funds generated by the managed care organization provider tax,*
37 *pursuant to Article 7.1 (commencing with Section 14199.80) or*
38 *any subsequent statute that continues the managed care*
39 *organization provider tax.*

1 (i) *The department may require Medi-Cal providers, Medi-Cal*
2 *managed care plans, and other persons or entities pertaining to*
3 *the Medi-Cal delivery system to submit information the department*
4 *deems necessary to implement and monitor compliance with this*
5 *article, other sections of law amended by the act that added this*
6 *section, or the PPI Terms and Conditions, at the times and in the*
7 *form and manner specified by the department.*

8 (j) (1) *The department may direct Medi-Cal managed care plans*
9 *to reimburse eligible providers furnishing the services subject to*
10 *PPI in accordance with one or more directed payment*
11 *methodologies pursuant to subsection (c) of Section 438.6 of Title*
12 *42 of the Code of Federal Regulations, and as set forth by other*
13 *sections of law amended by the act that added this section and by*
14 *the department in guidance issued pursuant to subdivision (b).*

15 (2) *Commencing with the first managed care rating period for*
16 *which the department documents in the annual rate certification*
17 *that the base period data submitted and attested to by Medi-Cal*
18 *managed care plans that is used by the department for the*
19 *development of capitation rates for the Medi-Cal managed care*
20 *delivery system reflects the increased reimbursement levels for a*
21 *service subject to PPI, the department may, following consultation*
22 *with affected stakeholders, elect to discontinue any directed*
23 *payment methodologies implemented for that service.*

24 (k) *The department, as appropriate and to the extent practicable,*
25 *shall consult with interested stakeholders regarding implementation*
26 *of applicable components of PPI in which they will participate.*

27 14124.163. (a) *For the purposes of this section:*

28 (1) *“Eligible providers” means physicians, physician assistants,*
29 *nurse practitioners, podiatrists, certified nurse midwives, licensed*
30 *midwives, doula providers, psychologists, licensed professional*
31 *clinical counselors, licensed clinical social workers, licensed*
32 *marriage and family therapists, optometrists, audiologists, and*
33 *community health workers.*

34 (2) *“Applicable professional services” means:*

35 (A) *Evaluation and management services associated with*
36 *primary care and specialist office visits, preventative care services,*
37 *and care management services.*

38 (B) *Maternal care services, including obstetric care services*
39 *and doula services.*

- 1 (C) *Outpatient behavioral health services that are not the*
2 *financial responsibility of county mental health plans operating*
3 *pursuant to Chapter 8.9 (commencing with Section 14700).*
4 (D) *Vaccine administration services, as specified by the*
5 *department.*
6 (E) *Vision services.*
7 (F) *Community health worker services, as described in the*
8 *approved Medi-Cal State Plan.*
9 (G) *Evaluation and management services associated with*
10 *emergency physician services.*
11 (H) *Other services commonly provided by primary care,*
12 *specialist, and hospital-based emergency physician and*
13 *non-physician health professionals as determined by the*
14 *department.*
15 (I) *Hearing aids and audiological services.*
16 (3) *“Applicable professional services” do not include:*
17 (A) *Abortion and family planning services.*
18 (B) *Other allied health services, clinical laboratory services,*
19 *radiology, and durable medical equipment.*
20 (C) *Outpatient hospital facility services other than services*
21 *described in subparagraphs (B) and (C) of paragraph (2).*
22 (4) *“Applicable percentage” means:*
23 (A) *With respect to the applicable services listed in*
24 *subparagraphs (A) and (B) of paragraph (2), 95 percent.*
25 (B) *With respect to the applicable services listed in*
26 *subparagraphs (C) to (E), inclusive, of paragraph (2), 87.5 percent.*
27 (C) *With respect to the applicable services listed in*
28 *subparagraph (F) of paragraph (2), 100 percent.*
29 (D) *With respect to the applicable services listed in*
30 *subparagraph (G) of paragraph (2), 90 percent.*
31 (E) *With respect to the applicable services listed in*
32 *subparagraphs (H) and (I) of paragraph (2), 80 percent.*
33 (b) *Notwithstanding any other law, for dates of service no sooner*
34 *than January 1, 2026, or on the effective date of any necessary*
35 *federal approvals as required by subdivision (d) of Section*
36 *14124.162, whichever is later, the department shall establish a*
37 *geographically adjusted fee schedule for applicable services*
38 *rendered by eligible providers consistent with the geographic*
39 *localities utilized by the federal Medicare Program.*

1 (c) (1) (A) Notwithstanding any other law, for dates of service
2 no sooner than January 1, 2025, or on the effective date of any
3 necessary federal approvals as required by subdivision (d) of
4 Section 14124.162, whichever is later, the reimbursement rates
5 for eligible providers rendering the services described in
6 subparagraph (G) of paragraph (2) of subdivision (a) shall be no
7 less than the applicable percentage of the lowest maximum
8 allowance established by the federal Medicare Program for the
9 same or similar services in effect as of January 1 of the calendar
10 year prior to the implementation of this subparagraph.

11 (B) Notwithstanding any other law, for dates of service no
12 sooner than January 1, 2026, or on the effective date of any
13 necessary federal approvals as required by subdivision (d) of
14 Section 14124.162, whichever is later, the reimbursement rates
15 for eligible providers rendering the applicable professional
16 services shall be no less than the applicable percentage of the
17 applicable, geographically adjusted, maximum allowance
18 established by the federal Medicare Program for the same or
19 similar services in effect as of January 1 of the calendar year prior
20 to the implementation of this subdivision for each geographic
21 locality established by the Medicare Program.

22 (2) The department shall develop and implement a methodology
23 for establishing reimbursement rates or payments for services for
24 which there is no maximum allowable rate established by the
25 federal Medicare Program. The department shall review this
26 methodology annually and may, in its sole discretion, modify the
27 methodology on a prospective basis.

28 (3) The department shall annually review and, subject to
29 appropriation by the Legislature, revise the reimbursement rates
30 established in accordance with this subdivision based on changes
31 to the applicable maximum allowable rate established by the
32 federal Medicare Program for the same or similar services. Any
33 revisions to the reimbursement rates shall be considered as part
34 of the annual budget development process and subject to the
35 provisions of subdivision (d) of Section 14124.162 and take effect
36 beginning no sooner than January 1, 2026, and thereafter on each
37 subsequent January 1 of the calendar year following the
38 department's annual review.

39 (d) Notwithstanding subdivision (b) of Section 14105.201, the
40 following shall apply:

1 (1) For contract periods during which subdivision (c) is
2 implemented, each Medi-Cal managed care plan shall reimburse
3 a network provider furnishing the services subject to subdivision
4 (c) at least the amount the network provider would be paid for
5 those services in the Medi-Cal fee-for-service delivery system, as
6 set forth by the department in the approved Medi-Cal State Plan
7 and guidance issued pursuant to subdivision (b) of Section
8 14124.162.

9 (2) In any instance where a Medi-Cal managed care plan and
10 network provider furnishing the services subject to subdivision (c)
11 mutually agree to reimbursement on a basis other than per-service
12 reimbursement, the Medi-Cal managed care plan shall account
13 for the reimbursement amount required pursuant to paragraph
14 (1) in determining the negotiated level of reimbursement and
15 disclose to the network provider the value of any reimbursement
16 increases associated with the changes to Medi-Cal managed care
17 program described in this section.

18 (3) (A) For the 2026 calendar year, the department shall require
19 Medi-Cal managed care plans to demonstrate compliance with
20 the requirements of paragraphs (1) and (2) in a form and manner
21 specified by the department.

22 (B) Subsequent to the 2026 calendar year, and subject to
23 paragraph (2) of subdivision (j) of Section 14124.162, the
24 department shall require Medi-Cal managed care plans to
25 redemonstrate compliance with the requirements of paragraphs
26 (1) and (2), in a form and manner specified by the department, no
27 less than once every four years, or more frequently as deemed
28 necessary by the department.

29 (C) This paragraph does not limit the department's authority
30 to audit, monitor, or oversee a Medi-Cal managed care plan's
31 compliance with applicable contractual, statutory, or other
32 requirements.

33 14124.164. (a) (1) Notwithstanding Section 51527 of Title 22
34 of the California Code of Regulations or any other law, for dates
35 of service no sooner than January 1, 2025, or on the effective date
36 of any necessary federal approvals as required by subdivision (d)
37 of Section 14124.162, whichever is later, the department shall
38 increase reimbursement for eligible providers rendering ground
39 emergency medical transport services.

1 (2) *The department may implement the reimbursement increases*
2 *described in paragraph (1) solely with respect to the per-transport*
3 *rate, with respect to both the per-transport and the mileage rates,*
4 *or in any other manner as deemed appropriate by the department.*

5 (3) *This subdivision shall not apply to an eligible provider as*
6 *defined in paragraph (1) of subdivision (a) of Section 14105.945.*

7 (b) *Notwithstanding Section 51527 of Title 22 of the California*
8 *Code of Regulations or any other law, for dates of service no*
9 *sooner than January 1, 2025, or on the effective date of any*
10 *necessary federal approvals as required by subdivision (d) of*
11 *Section 14124.162, whichever is later, the department may vary*
12 *the reimbursement increases described in subdivision (a), or*
13 *reimbursement rates for ground emergency medical transport*
14 *services, based on complexity or the geographic localities utilized*
15 *by the federal Medicare Program, may categorize localities into*
16 *rural tiers, and may vary the amount of the rural adjustment per*
17 *tier from those utilized by the Medicare Program to reflect a*
18 *California-specific index of localities and adjustment factors.*
19 *Nothing in this subdivision shall be construed to require the*
20 *department to reimburse providers rendering ground emergency*
21 *medical transport services the rates utilized by the Medicare*
22 *Program or to replicate the rural adjustment factors, or any other*
23 *factors, utilized by the Medicare Program.*

24 (c) *Each applicable Medi-Cal managed care health plan shall*
25 *satisfy its obligation under Section 438.114(c) of Title 42 of the*
26 *Code of Federal Regulations for emergency medical transports*
27 *and shall provide payment to noncontract emergency medical*
28 *transport providers consistent with Section 1396u-2(b)(2)(D) of*
29 *Title 42 of the United States Code. Effective upon implementation*
30 *of this section, and for each state fiscal year thereafter for which*
31 *this section is operative, the amounts a noncontract emergency*
32 *medical transport provider could collect if the beneficiary received*
33 *medical assistance other than through enrollment in a Medi-Cal*
34 *managed care health plan pursuant to Section 1396u-2(b)(2)(D)*
35 *of Title 42 of the United States Code shall be the resulting*
36 *fee-for-service payment schedule amounts after the application of*
37 *this section.*

38 (d) *The department shall implement the reimbursement increases*
39 *specified in subdivision (a) in amounts that are designed to target*
40 *increased state fund expenditures of equal to the annualized*

1 amount set forth in the state fiscal year 2024–25 budget for the
2 first year of implementation in aggregate across both the Medi-Cal
3 fee-for-service and managed care delivery systems. The
4 reimbursement increases established pursuant to this methodology
5 shall continue at these levels for each year thereafter, subject to
6 subdivision (e).

7 (e) The department may annually review and revise the
8 reimbursement increases established in accordance with
9 subdivision (a). Any revisions shall be subject to the provisions of
10 subdivision (d) of Section 14124.162 and take effect beginning no
11 sooner than January 1, 2026, and thereafter on each subsequent
12 January 1 of the calendar year following the department's annual
13 review.

14 14124.165. (a) (1) Notwithstanding any other law, for dates
15 of service no sooner than January 1, 2025, the base reimbursement
16 rates for eligible providers rendering Medi-Cal covered abortion
17 services identified by the department, shall be increased in the
18 fee-for-service delivery system such that, in combination with the
19 projected actuarially equivalent impact on the managed care
20 delivery system expenditures, the projected cost of the base
21 reimbursement rate increases on an annualized basis is equal, as
22 determined by the department, to the annualized amount set forth
23 in the state fiscal year 2024–25 budget.

24 (2) The reimbursement rate increases described in paragraph
25 (1) shall account for, and be inclusive of, the exemption of these
26 services from payment reductions pursuant to Section 14105.192,
27 and may be geographically adjusted as deemed appropriate by
28 the department.

29 (b) For contract periods during which subdivision (a) is
30 implemented, each Medi-Cal managed care plan shall reimburse
31 eligible providers furnishing the services subject to subdivision
32 (a) no less than the amounts established pursuant to subdivision
33 (a) as directed by the department in guidance issued pursuant to
34 subdivision (b) of Section 14124.162.

35 14124.166. (a) Beginning for dates of service no sooner than
36 January 1, 2025, or on the effective date of any necessary federal
37 approvals as required by subdivision (d) of Section 14124.162,
38 whichever is later, the department may implement a supplemental
39 payment program for services provided under the Family Planning,

1 *Access, Care, and Treatment program, as described in subdivision*
2 *(aa) of Section 14132.*

3 *(b) The department shall develop, establish, and maintain the*
4 *methodology, eligibility criteria, conditions, and payment amounts*
5 *for the supplemental payments described in this section.*

6 *14124.167. (a) For the purposes of this section, the following*
7 *definitions apply:*

8 *(1) Beginning for dates of service on or after January 1, 2025,*
9 *“applicable services” means the following services:*

10 *(A) Emergency medical air transportation services as described*
11 *in Section 76000.10 of the Government Code.*

12 *(B) Community-based adult services, as described in Section*
13 *14186.3 and as covered pursuant to subdivision (e) of Section*
14 *14184.201.*

15 *(C) Pediatric day health care, as described in Section 14132.10*
16 *and Section 1760.2 of the Health and Safety Code.*

17 *(D) Services provided in a congregate living health facility as*
18 *defined in subdivision (i) of Section 1250 of the Health and Safety*
19 *Code.*

20 *(2) Beginning for dates of service on or after January 1, 2026,*
21 *“applicable services” means the following services:*

22 *(A) Services described in paragraph (1).*

23 *(B) Nonemergency medical transportation services as described*
24 *in Section 51323 of Title 22 of the California Code of Regulations.*

25 *(C) Private duty nursing as described in Section 14105.13 and*
26 *Section 1743.2 of the Health and Safety Code.*

27 *(b) Beginning for dates of service on or after January 1, 2025,*
28 *or on the effective date of any necessary federal approvals as*
29 *required by subdivision (d) of Section 14124.162, whichever is*
30 *later, the department shall implement reimbursement increases*
31 *for applicable services in the fee-for-service delivery system such*
32 *that, in combination with the projected actuarially equivalent*
33 *impact on the managed care delivery system expenditures, as*
34 *applicable, the projected nonfederal share cost of the*
35 *reimbursement increases on an annualized basis is equal, as*
36 *determined by the department, to the annualized amount set forth*
37 *in the state fiscal year 2024–25 budget.*

38 *14124.168. If the voters approve the addition of Chapter 7.5*
39 *(commencing with Section 14199.100) to this part at the November*

1 5, 2024, statewide general election, this article shall be repealed
2 as of January 1, 2025.

3 SEC. 64. Section 14131.05 of the Welfare and Institutions Code
4 is amended to read:

5 14131.05. (a) Notwithstanding any other provision of this
6 chapter or Chapter 8 (commencing with Section 14200), optional
7 hearing aid benefits are subject to per beneficiary benefit cap
8 amounts under the Medi-Cal program.

9 (b) For the purposes of this section, “benefit cap amount” means
10 the maximum amount of Medi-Cal coverage for optional hearing
11 aid benefits as specified in subdivision (c), for each beneficiary,
12 for each fiscal year.

13 (c) (1) If the voters approve the addition of Chapter 7.5
14 (commencing with Section 14199.100) to this part at the November
15 5, 2024, statewide general election, hearing aid benefits are subject
16 to a benefit cap amount of one thousand five hundred ten dollars
17 (\$1,510).

18 ~~(e) Hearing aid~~

19 (2) Notwithstanding paragraph (1), if the voters do not approve
20 the addition of Chapter 7.5 (commencing with Section 14199.100)
21 to this part at the November 5, 2024, statewide general election,
22 hearing aid benefits are subject to a benefit cap amount of no less
23 than one thousand five hundred ten dollars (\$1,510). Under that
24 circumstance, the benefit cap amount shall be set by the department
25 and may be adjusted annually, any revisions to the benefit cap
26 shall be subject to the provisions of Sections 14124.162 and
27 14124.163.

28 (d) Pregnancy-related benefits and benefits for the treatment of
29 other conditions that might complicate the pregnancy are not
30 subject to the benefit cap amount in subdivision (c).

31 (e) The benefit cap amount in subdivision (c) does not apply to
32 the following:

33 (1) Beneficiaries under the Early and Periodic Screening,
34 Diagnosis, and Treatment Program.

35 (2) Beneficiaries receiving long-term care in a nursing facility
36 that is both of the following:

37 (A) A skilled nursing facility or intermediate care facility as
38 defined in subdivisions (c), (d), (e), (g), and (h), respectively, of
39 Section 1250 of the Health and Safety Code, and facilities
40 providing continuous skilled nursing care to developmentally

1 disabled individuals pursuant to the program established by Section
2 14132.20.

3 (B) A licensed nursing facility pursuant to subdivision (k) of
4 Section 1250 of the Health and Safety Code.

5 (f) For managed care health plans that contract with the
6 department pursuant to this chapter or Chapter 8 (commencing
7 with Section 14200), except for contracts with the Senior Care
8 Action Network and AIDS Healthcare Foundation, payments for
9 optional hearing aid benefits shall be reduced by the actuarial
10 equivalent amount of the benefit reductions resulting from the
11 implementation of the benefit cap amount specified in this section
12 pursuant to contract amendments or change orders effective on
13 July 1, 2011, or any date thereafter.

14 (g) This section shall be implemented only to the extent
15 permitted by federal law.

16 (h) Notwithstanding the rulemaking provisions of the
17 Administrative Procedure Act (Chapter 3.5 (commencing with
18 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
19 Code), the department may implement the provisions of this section
20 by means of all-county letters, provider bulletins, or similar
21 instructions, without taking further regulatory action.

22 (i) This section shall be implemented on the first day of the first
23 calendar month following 210 days after the effective date of this
24 section, or on the first day of the first calendar month following
25 60 days after the date the department secures all necessary federal
26 approvals to implement this section, whichever is later. If the
27 implementation date occurs after July 1, 2011, then the benefit cap
28 described in subdivision (c) for the first year of implementation
29 shall be applied from the implementation date through June 30 of
30 the state fiscal year in which implementation commences.
31 Thereafter, the benefit cap shall apply on a state fiscal year basis.

32 *SEC. 65. Section 14154 of the Welfare and Institutions Code*
33 *is amended to read:*

34 14154. (a) (1) The department shall establish and maintain a
35 plan whereby costs for county administration of the determination
36 of eligibility for benefits under this chapter will be effectively
37 controlled within the amounts annually appropriated for that
38 administration. The plan, to be known as the County Administrative
39 Cost Control Plan, shall establish standards and performance
40 criteria, including workload, productivity, and support services

1 standards, to which counties shall adhere. The plan shall include
2 standards for controlling eligibility determination costs that are
3 incurred by performing eligibility determinations at county
4 hospitals, or that are incurred due to the outstationing of any other
5 eligibility function. Except as provided in Section 14154.15,
6 reimbursement to a county for outstationed eligibility functions
7 shall be based solely on productivity standards applied to that
8 county's welfare department office.

9 (2) (A) The plan shall delineate both of the following:

10 (i) The process for determining county administration base costs,
11 which include salaries and benefits, support costs, and staff
12 development.

13 (ii) The process for determining funding for caseload changes,
14 cost-of-living adjustments, and program and other changes.

15 (B) The annual county budget survey document utilized under
16 the plan shall be constructed to enable the counties to provide
17 sufficient detail to the department to support their budget requests.

18 (3) The plan shall be part of a single state plan, jointly developed
19 by the department and the State Department of Social Services, in
20 conjunction with the counties, for administrative cost control for
21 the California Work Opportunity and Responsibility to Kids
22 (CalWORKs), CalFresh, and Medical Assistance (Medi-Cal)
23 programs. Allocations shall be made to each county and shall be
24 limited by and determined based upon the County Administrative
25 Cost Control Plan. In administering the plan to control county
26 administrative costs, the department shall not allocate state funds
27 to cover county cost overruns that result from county failure to
28 meet requirements of the plan. The department and the State
29 Department of Social Services shall budget, administer, and
30 allocate state funds for county administration in a uniform and
31 consistent manner.

32 (4) The department and county welfare departments shall
33 develop procedures to ensure the data clarity, consistency, and
34 reliability of information contained in the county budget survey
35 document submitted by counties to the department. These
36 procedures shall include the format of the county budget survey
37 document and process, data submittal and its documentation, and
38 the use of the county budget survey documents for the development
39 of determining county administration costs. Communication
40 between the department and the county welfare departments shall

1 be ongoing as needed regarding the content of the county budget
2 surveys and any potential issues to ensure the information is
3 complete and well understood by involved parties. Any changes
4 developed pursuant to this section shall be incorporated within the
5 state's annual budget process by no later than the 2011–12 fiscal
6 year.

7 (5) The department shall provide a clear narrative description
8 along with fiscal detail in the Medi-Cal estimate package, submitted
9 to the Legislature in January and May of each year, of each
10 component of the county administrative funding for the Medi-Cal
11 program. This shall describe how the information obtained from
12 the county budget survey documents was utilized and, if applicable,
13 modified and the rationale for the changes.

14 (6) Notwithstanding any other law, the department shall develop
15 and implement, in consultation with county program and fiscal
16 representatives, a new budgeting methodology for Medi-Cal county
17 administrative costs that reflects the impact of PPACA
18 implementation on county administrative work. The new budgeting
19 methodology shall be used to reimburse counties for eligibility
20 processing and case maintenance for applicants and beneficiaries.

21 (A) The budgeting methodology may include, but is not limited
22 to, identification of the costs of eligibility determinations for
23 applicants, and the costs of eligibility redeterminations and case
24 maintenance activities for recipients, for different groupings of
25 cases, based on variations in time and resources needed to conduct
26 eligibility determinations. The calculation of time and resources
27 shall be based on the following factors: complexity of eligibility
28 rules, ongoing eligibility requirements, and other factors as
29 determined appropriate by the department. The development of
30 the new budgeting methodology may include, but is not limited
31 to, county survey of costs, time and motion studies, in-person
32 observations by department staff, data reporting, and other factors
33 deemed appropriate by the department.

34 (B) The new budgeting methodology shall be clearly described,
35 state the necessary data elements to be collected from the counties,
36 and establish the timeframes for counties to provide the data to
37 the state.

38 (C) The new budgeting methodology developed pursuant to this
39 paragraph shall be implemented no sooner than the 2015–16 fiscal

1 year. The department may develop a process for counties to phase
2 in the requirements of the new budgeting methodology.

3 (D) The department shall provide the new budgeting
4 methodology to the legislative fiscal committees by March 1 of
5 the fiscal year immediately preceding the first fiscal year of
6 implementation of the new budgeting methodology.

7 (E) To the extent that the funding for the county budgets
8 developed pursuant to the new budget methodology is not fully
9 appropriated in any given fiscal year, the department, with input
10 from the counties, shall identify and consider options to align
11 funding and workload responsibilities.

12 (F) For purposes of this paragraph, “PPACA” means the federal
13 Patient Protection and Affordable Care Act (Public Law 111-148),
14 as amended by the federal Health Care and Education
15 Reconciliation Act of 2010 (Public Law 111-152) and any
16 subsequent amendments.

17 (G) Notwithstanding Chapter 3.5 (commencing with Section
18 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
19 the department may implement, interpret, or make specific this
20 paragraph by means of all-county letters, plan letters, plan or
21 provider bulletins, or similar instructions until the time any
22 necessary regulations are adopted. The department shall adopt
23 regulations by July 1, 2017, in accordance with the requirements
24 of Chapter 3.5 (commencing with Section 11340) of Part 1 of
25 Division 3 of Title 2 of the Government Code. Beginning six
26 months after the implementation of the new budgeting methodology
27 pursuant to this paragraph, and notwithstanding Section 10231.5
28 of the Government Code, the department shall provide a status
29 report to the Legislature on a semiannual basis, in compliance with
30 Section 9795 of the Government Code, until regulations have been
31 adopted.

32 (b) Nothing in this section, Section 15204.5, or Section 18906
33 shall be construed to limit the administrative or budgetary
34 responsibilities of the department in a manner that would violate
35 Section 14100.1, and thereby jeopardize federal financial
36 participation under the Medi-Cal program.

37 (c) (1) The Legislature finds and declares that in order for
38 counties to do the work that is expected of them, it is necessary
39 that they receive adequate funding, including adjustments for
40 reasonable annual cost-of-doing-business increases. The Legislature

1 further finds and declares that linking appropriate funding for
2 county Medi-Cal administrative operations, including annual
3 cost-of-doing-business adjustments, with performance standards
4 will give counties the incentive to meet the performance standards
5 and enable them to continue to do the work they do on behalf of
6 the state. It is therefore the Legislature's ~~intent~~ *intent, upon an*
7 *appropriation by the Legislature for this purpose*, to provide
8 appropriate funding to the counties for the effective administration
9 of the Medi-Cal program at the local level to ensure that counties
10 can reasonably meet the purposes of the performance measures as
11 contained in this section.

12 (2) It is the intent of the Legislature to not appropriate funds for
13 the cost-of-doing-business adjustment for the 2008–09, 2009–10,
14 2010–11, 2011–12, 2012–13, 2014–15, 2015–16, 2016–17, and
15 2017–18 fiscal ~~years~~ *years and the 2024–25 to 2027–28, inclusive,*
16 *fiscal years.*

17 (d) The department is responsible for the Medi-Cal program in
18 accordance with state and federal law. A county shall determine
19 Medi-Cal eligibility in accordance with state and federal law. If
20 in the course of its duties the department becomes aware of
21 accuracy problems in any county, the department shall, within
22 available resources, provide training and technical assistance as
23 appropriate. This section shall not be interpreted to eliminate any
24 remedy otherwise available to the department to enforce accurate
25 county administration of the program. In administering the
26 Medi-Cal eligibility process, each county shall meet the following
27 performance standards each fiscal year:

28 (1) Complete eligibility determinations as follows:

29 (A) Ninety percent of the general applications without applicant
30 errors and are complete shall be completed within 45 days.

31 (B) Ninety percent of the applications for Medi-Cal based on
32 disability shall be completed within 90 days, excluding delays by
33 the state.

34 (2) (A) The department shall establish best-practice guidelines
35 for expedited enrollment of newborns into the Medi-Cal program,
36 preferably with the goal of enrolling newborns within 10 days after
37 the county is informed of the birth. The department, in consultation
38 with counties and other stakeholders, shall work to develop a
39 process for expediting enrollment for all newborns, including those
40 born to mothers receiving CalWORKs assistance.

1 (B) Upon the development and implementation of the
2 best-practice guidelines and expedited processes, the department
3 and the counties may develop an expedited enrollment timeframe
4 for newborns that is separate from the standards for all other
5 applications, to the extent that the timeframe is consistent with
6 these guidelines and processes.

7 (3) Perform timely annual redeterminations, as follows:

8 (A) Ninety percent of the annual redetermination forms shall
9 be mailed to the recipient by the anniversary date.

10 (B) Ninety percent of the annual redeterminations shall be
11 completed within 60 days of the recipient's annual redetermination
12 date for those redeterminations based on forms that are complete
13 and have been returned to the county by the recipient in a timely
14 manner.

15 (C) Ninety percent of those annual redeterminations where the
16 redetermination form has not been returned to the county by the
17 recipient shall be completed by sending a notice of action to the
18 recipient within 45 days after the date the form was due to the
19 county.

20 (e) The department shall develop procedures in collaboration
21 with the counties and stakeholder groups for determining county
22 review cycles, sampling methodology and procedures, and data
23 reporting.

24 (f) On January 1 of each year, each applicable county, as
25 determined by the department, shall report to the department on
26 the county's results in meeting the performance standards specified
27 in this section. The report shall be subject to verification by the
28 department. County reports shall be provided to the public upon
29 written request.

30 (g) If the department finds that a county is not in compliance
31 with one or more of the standards set forth in this section, the
32 county shall, within 60 days, submit a corrective action plan to the
33 department for approval. The corrective action plan shall, at a
34 minimum, include steps that the county shall take to improve its
35 performance on the standard or standards with which the county
36 is out of compliance. The plan shall establish interim benchmarks
37 for improvement that shall be expected to be met by the county in
38 order to avoid a sanction.

39 (h) (1) If a county does not meet the performance standards for
40 completing eligibility determinations and redeterminations as

1 specified in this section, the department may, at its sole discretion,
2 reduce the allocation of funds to that county in the following year
3 by 2 percent. Any funds so reduced may be restored by the
4 department if, in the determination of the department, sufficient
5 improvement has been made by the county in meeting the
6 performance standards during the year for which the funds were
7 reduced. If the county continues not to meet the performance
8 standards, the department may reduce the allocation by an
9 additional 2 percent for each year thereafter in which sufficient
10 improvement has not been made to meet the performance standards.

11 (2) No reduction of the allocation of funds to a county shall be
12 imposed pursuant to this subdivision for failure to meet
13 performance standards during any period of time in which the
14 cost-of-doing-business increase is suspended.

15 (i) Notwithstanding Chapter 3.5 (commencing with Section
16 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
17 and except as provided in subparagraph (G) of paragraph (6) of
18 subdivision (a), the department shall, without taking any further
19 regulatory action, implement, interpret, or make specific this
20 section and any applicable federal waivers and state plan
21 amendments by means of all-county letters or similar instructions.

22 *SEC. 66. Section 14165.58 of the Welfare and Institutions Code*
23 *is repealed.*

24 ~~14165.58.—(a) The department shall design and implement, in~~
25 ~~consultation with nondesignated public hospitals, an~~
26 ~~intergovernmental transfer program relating to Medi-Cal managed~~
27 ~~care services provided by nondesignated public hospitals in order~~
28 ~~to increase capitation payments for the purpose of increasing their~~
29 ~~reimbursement.~~

30 ~~(b) The increased capitation payments under this section shall~~
31 ~~be actuarially equivalent to the increased fee-for-service payments~~
32 ~~made pursuant to Section 14165.57 to the extent permissible under~~
33 ~~federal law.~~

34 ~~(c) This section shall be implemented on the later of January 1,~~
35 ~~2014, or the date on which all necessary federal approvals have~~
36 ~~been received, and only to the extent intergovernmental transfers~~
37 ~~from nondesignated public hospitals are provided for this purpose.~~

38 ~~(d) Participation in the intergovernmental transfers under this~~
39 ~~section is voluntary on the part of the transferring entities for the~~
40 ~~purposes of all applicable federal laws.~~

1 ~~(e) This section shall be implemented only to the extent federal~~
2 ~~financial participation is available for the reimbursement specified~~
3 ~~in subdivision (b).~~

4 ~~(f) This section shall be implemented only to the extent federal~~
5 ~~financial participation is not jeopardized.~~

6 ~~(g) To the extent that the director determines that the payments~~
7 ~~do not comply with the federal Medicaid requirements, the director~~
8 ~~retains the discretion not to implement an intergovernmental~~
9 ~~transfer and may adjust the payment as necessary to comply with~~
10 ~~federal Medicaid requirements.~~

11 ~~(h) To the extent federal approval is secured, the increased~~
12 ~~capitation payments under this section may cover dates of service~~
13 ~~on or after January 1, 2014.~~

14 ~~(i) Notwithstanding Chapter 3.5 (commencing with Section~~
15 ~~11340) of Part 1 of Division 3 of Title 2 of the Government Code,~~
16 ~~the department shall implement this section by means of policy~~
17 ~~letters or similar instructions, without taking further regulatory~~
18 ~~action. Notwithstanding Section 10231.5 of the Government Code,~~
19 ~~the department shall provide the Joint Legislative Budget~~
20 ~~Committee and the fiscal and appropriate policy committees of~~
21 ~~the Legislature a status update of the implementation of this section~~
22 ~~on January 1, 2014, and annually thereafter.~~

23 *SEC. 67. Section 14184.10 of the Welfare and Institutions Code*
24 *is amended to read:*

25 14184.10. For purposes of this article, the following definitions
26 shall apply:

27 (a) “Demonstration project” means the California Medi-Cal
28 2020 Demonstration Project, Number 11-W-00193/9, as approved
29 by the federal Centers for Medicare and Medicaid Services,
30 effective for the period from December 30, 2015, to December
31 31, 2020, inclusive, and any applicable extension period.

32 (b) “Demonstration term” means the entire period during which
33 the demonstration project is in effect, as approved by the federal
34 Centers for Medicare and Medicaid Services, including any
35 applicable extension period.

36 (c) “Demonstration year” means the demonstration year as
37 identified in the Special Terms and Conditions that corresponds
38 to a specific period of time as set forth in paragraphs (1) to (6),
39 inclusive. Individual programs under the demonstration project

1 may be operated on program years that differ from the
2 demonstration years identified in paragraphs (1) to (6), inclusive.

3 (1) Demonstration year 11 corresponds to the period of January
4 1, 2016, to June 30, 2016, inclusive.

5 (2) Demonstration year 12 corresponds to the period of July 1,
6 2016, to June 30, 2017, inclusive.

7 (3) Demonstration year 13 corresponds to the period of July 1,
8 2017, to June 30, 2018, inclusive.

9 (4) Demonstration year 14 corresponds to the period of July 1,
10 2018, to June 30, 2019, inclusive.

11 (5) Demonstration year 15 corresponds to the period of July 1,
12 2019, to June 30, 2020, inclusive.

13 (6) Demonstration year 16 corresponds to the period of July 1,
14 2020, to December 31, 2020, inclusive.

15 (d) “Dental Transformation Initiative” or “DTI” means the
16 waiver program intended to improve oral health services for
17 children, as authorized under the Special Terms and Conditions
18 and described in Section 14184.70.

19 (e) “Designated state health program” has the same meaning as
20 set forth in the Special Terms and Conditions.

21 (f) (1) “Designated public hospital” means any one of the
22 following hospitals, and any successor, including any restructured,
23 reorganized, or differently named hospital, which is operated by
24 a county, a city and county, the University of California, or a
25 special hospital authority described in Chapter 5 (commencing
26 with Section 101850) or Chapter 5.5 (commencing with Section
27 101852) of Part 4 of Division 101 of the Health and Safety Code,
28 or any additional public hospital, *hospital* to the extent identified
29 as a “designated public hospital” in the Special Terms and
30 Conditions or, effective July 1, 2021, the CalAIM Terms and
31 ~~Conditions~~, *Conditions* as defined in Section 14184.101. Unless
32 otherwise provided for in law, in the ~~Medi-Cal~~ *California Medicaid*
33 State Plan, or in the Special Terms and Conditions, all references
34 in law to a designated public hospital as defined in subdivision (d)
35 of Section 14166.1 shall be deemed to refer to a hospital described
36 in this section effective as of January 1, 2016, except as provided
37 in paragraph ~~(2)~~; (2) *or, for a hospital not otherwise listed in*
38 *subparagraphs (A) through (T), inclusive, as of the date specified*
39 *in the applicable Terms and Conditions or State Plan amendment:*

40 (A) UC Davis Medical Center.

- 1 (B) UC Irvine Medical Center.
- 2 (C) UC San Diego Medical ~~Center~~. *Center, including, effective*
- 3 *no sooner than January 1, 2024, the East Campus Medical Center*
- 4 *formerly known as Alvarado Hospital Medical Center.*
- 5 (D) UC San Francisco Medical Center.
- 6 (E) UCLA Medical Center.
- 7 (F) Santa Monica/UCLA Medical Center, also known as the
- 8 Santa Monica-UCLA Medical Center and Orthopaedic Hospital.
- 9 (G) LA County Health System Hospitals:
- 10 (i) LA County Harbor/UCLA Medical Center.
- 11 (ii) LA County Olive View UCLA Medical Center.
- 12 (iii) LA County Rancho Los Amigos National Rehabilitation
- 13 Center.
- 14 ~~(iv) LA County University of Southern California General~~
- 15 ~~Medical Center.~~
- 16 (H) Alameda Health System Hospitals, including the following:
- 17 (i) Highland Hospital, including the Fairmont and John George
- 18 Psychiatric facilities.
- 19 (ii) Alameda Hospital.
- 20 (iii) San Leandro Hospital.
- 21 (I) Arrowhead Regional Medical Center.
- 22 (J) Contra Costa Regional Medical Center.
- 23 (K) Kern Medical Center.
- 24 (L) Natividad Medical Center.
- 25 (M) Riverside University Health System-Medical Center.
- 26 (N) San Francisco General Hospital.
- 27 (O) San Joaquin General Hospital.
- 28 (P) San Mateo Medical Center.
- 29 (Q) Santa Clara Valley Medical Center.
- 30 (R) Ventura County Medical Center.
- 31 (S) *The following hospitals, effective no sooner than April 1,*
- 32 *2024:*
- 33 *(i) UCLA West Valley Medical Center (formerly West Hills*
- 34 *Hospital and Medical Center).*
- 35 *(ii) UCI Health – Fountain Valley.*
- 36 *(iii) UCI Health – Lakewood.*
- 37 *(iv) UCI Health – Placentia Linda.*
- 38 *(v) UCI Health – Los Alamitos.*
- 39 (T) *The following hospitals, effective no sooner than the later*
- 40 *of July 1, 2024, or the first day of the quarter following the closing*

1 *of the applicable affiliation transaction with the University of*
2 *California, San Francisco:*

3 (i) *UCSF Health – St. Mary’s (formerly St. Mary’s Medical*
4 *Center).*

5 (ii) *UCSF Health – Saint Francis (formerly Saint Francis*
6 *Memorial Hospital).*

7 (2) For purposes of the following reimbursement methodologies,
8 the hospitals identified in clauses (ii) and (iii) of subparagraph (H)
9 of paragraph (1) shall be deemed to be a designated public hospital
10 as of the following effective dates:

11 (A) For purposes of the fee-for-service payment methodologies
12 established and implemented under Section 14166.4, the effective
13 date shall be the date described in paragraph (3) of subdivision (a)
14 of Section 14184.30.

15 (B) For purposes of Article 5.230 (commencing with Section
16 14169.50), the effective date shall be January 1, 2017.

17 (g) “Disproportionate share hospital provisions of the Medi-Cal
18 State Plan” means those applicable provisions contained in
19 Attachment 4.19-A of the California Medicaid state plan, approved
20 by the federal Centers for Medicare and Medicaid Services, that
21 implement the payment adjustment program for disproportionate
22 share hospitals.

23 (h) “Federal disproportionate share hospital allotment” means
24 the amount specified for California under Section 1396r-4(f) of
25 Title 42 of the United States Code for a federal fiscal year.

26 (i) “Federal medical assistance percentage” means the federal
27 medical assistance percentage applicable for federal financial
28 participation purposes for medical services under the Medi-Cal
29 State Plan pursuant to Section 1396b(a)(1) of Title 42 of the United
30 States Code.

31 (j) “Global Payment Program” or “GPP” means the payment
32 program authorized under the demonstration project and described
33 in Section 14184.40 that assists participating public health care
34 systems that provide health care for the uninsured and that
35 promotes the delivery of more cost-effective, higher-value health
36 care services and activities.

37 (k) “Nondesignated public hospital” means a public hospital as
38 that term is defined in paragraph (25) of subdivision (a) of Section
39 14105.98, excluding designated public hospitals.

1 (l) “Nonfederal share percentage” means the difference between
2 100 percent and the federal medical assistance percentage.

3 (m) “PRIME” means the Public Hospital Redesign and
4 Incentives in Medi-Cal program authorized under the
5 demonstration project and described in Section 14184.50.

6 (n) “Total computable disproportionate share hospital allotment”
7 means the federal disproportionate share hospital allotment for a
8 federal fiscal year, divided by the applicable federal medical
9 assistance percentage with respect to that same federal fiscal year.

10 (o) “Special Terms and Conditions” means those terms and
11 conditions issued by the federal Centers for Medicare and Medicaid
12 Services, including all attachments to those terms and conditions
13 and any subsequent amendments approved by the federal Centers
14 for Medicare and Medicaid Services, that apply to the
15 demonstration project.

16 (p) “Uninsured” means an individual for whom there is no
17 source of third-party coverage for the health care services the
18 individual receives, as determined pursuant to the Special Terms
19 and Conditions.

20 (q) “Whole Person Care pilot program” means a local
21 collaboration among local governmental agencies, Medi-Cal
22 managed care plans, health care and behavioral health providers,
23 or other community organizations, as applicable, that are approved
24 by the department to implement strategies to serve one or more
25 identified target populations, pursuant to Section 14184.60 and
26 the Special Terms and Conditions.

27 *SEC. 68. Section 14197.4 of the Welfare and Institutions Code*
28 *is amended to read:*

29 14197.4. (a) The Legislature finds and declares all of the
30 following:

31 (1) Designated public hospital systems play an essential role in
32 the Medi-Cal program, providing high-quality care to a
33 disproportionate number of low-income Medi-Cal and uninsured
34 populations in the state. Because Medi-Cal covers approximately
35 one-third of the state’s population, the strength of these essential
36 public health care systems is of critical importance to the health
37 and welfare of the people of California.

38 (2) Designated public hospital systems provide comprehensive
39 health care services to low-income patients and lifesaving trauma,
40 burn, and disaster-response services for entire communities, and

1 train the next generation of doctors and other health care
2 professionals, such as nurses and paramedical professionals, who
3 are critical to new team-based care models that achieve more
4 efficient and patient-centered care.

5 (3) The Legislature intends to continue to provide levels of
6 support for designated public hospital systems in light of their
7 reliance on Medi-Cal funding to provide quality care to everyone,
8 regardless of insurance status, ability to pay, or other circumstance,
9 the significant proportion of Medi-Cal services provided under
10 managed care by these public hospital systems, and ~~new~~ federal
11 requirements related to Medicaid managed care.

12 (4) It is the intent of the Legislature that Medi-Cal managed
13 care plans and designated public hospital systems that may enter
14 into contracts to provide services for Medi-Cal beneficiaries shall
15 in good faith negotiate for, and implement, contract rates, the
16 provision and arrangement of services and member assignment
17 that are sufficient to ensure continued participation by Medi-Cal
18 managed care plans and designated public hospital systems and
19 to maintain access to services for Medi-Cal managed care
20 beneficiaries and other low-income patients.

21 (5) It is the intent of the Legislature that, in order to ensure both
22 the financial viability of Medi-Cal managed care plans and support
23 the participation of designated public hospital systems in Medi-Cal
24 managed care, the department shall provide Medi-Cal managed
25 care plans actuarially sound rates reflecting the directed contract
26 services payments implemented to comply with ~~the new~~ federal
27 requirements relating to Medicaid managed care.

28 (b) Commencing with the 2017–18 state fiscal ~~year~~, *year for*
29 *designated public hospital systems, and commencing with the 2023*
30 *calendar year for district and municipal public hospitals*, and for
31 each state fiscal year or rate year, as applicable, thereafter, and
32 notwithstanding any other law, the department shall require each
33 Medi-Cal managed care plan to increase contract services payments
34 to the designated public hospital systems *and to district and*
35 *municipal public hospitals* by amounts determined under a directed
36 payment methodology that meets federal requirements and as
37 described in this subdivision. The directed payments may be
38 determined and applied as distributions from directed payment
39 pools, ~~as a uniform percentage increase, or other basis~~, *uniform*

1 *dollar or percentage increases, or on other bases, and may*
2 *incorporate acuity adjustments or other factors.*

3 (1) The directed payments may separately account for inpatient
4 hospital services and noninpatient hospital services. The directed
5 payments shall be developed and applied separately for classes of
6 designated public hospital ~~systems~~; *systems and district and*
7 *municipal public hospitals*. The department, in consultation with
8 the designated public hospital ~~systems~~; *systems and district and*
9 *municipal public hospitals, as applicable*, shall establish the classes
10 of designated public hospital systems *and district and municipal*
11 *public hospitals, as applicable*, consistent with the objectives set
12 forth in subdivisions (a) and (d) and that take into account
13 differences in services provided, service delivery systems, and ~~in~~
14 the level of risk assumed from *Medi-Cal* managed care plans. ~~The~~
15 *For designated public hospital systems, the* factors to be considered
16 shall include, but are not limited to, operation by the University
17 of California, designated public hospital systems comprised of
18 multiple acute care hospitals, level 1 or level 2 trauma designation,
19 and the assumption of risk for the provision of inpatient hospital
20 services.

21 (2) To the extent permitted by federal law and to meet the
22 objectives identified in subdivisions (a) and (d), the department
23 shall develop and implement the directed payment program in
24 consultation with designated public hospital systems *and district*
25 *and municipal public hospitals* or *Medi-Cal* managed care plans,
26 or ~~both~~, *all*, as follows:

27 (A) The department, in consultation with the designated public
28 hospital ~~systems~~; *systems and district and municipal public*
29 *hospitals, as applicable*, shall annually determine on a prospective
30 basis the aggregate amount of payments that will be directed to
31 each class of designated public hospital systems *and district and*
32 *municipal public hospitals* pursuant to this subdivision and the
33 classification of each designated public hospital ~~system~~; *system*
34 *and district and municipal public hospital*. Once the department
35 determines the classification for each designated public hospital
36 system *and district and municipal public hospital* for a particular
37 state fiscal year or rate year, that classification shall not be eligible
38 to change until no sooner than the subsequent year. For state fiscal
39 years or rate years following the 2017–18 state fiscal year, the
40 aggregate amounts of payments to a class of designated public

1 hospital systems shall account for trend adjustments to the
2 aggregate amounts available during the prior year, subject to any
3 modifications to account for changes in the classification of
4 designated public hospital systems, changes required by federal
5 law, changes to account for the size of the payments made pursuant
6 to subdivision (c), or other material changes.

7 (B) The department, in consultation with the designated public
8 hospital ~~systems~~, *systems and district and municipal public*
9 *hospitals, as applicable*, shall develop the methodologies for
10 determining the required directed payments for each designated
11 public hospital ~~system~~. *system and district and municipal public*
12 *hospital*.

13 (C) To the extent necessary to meet the objectives identified in
14 subdivisions (a) and (d) or to comply with federal requirements,
15 the department may, in consultation with the designated public
16 hospital ~~systems~~, *systems and district and municipal public*
17 *hospitals, as applicable*, adjust or modify the amounts of the
18 aggregate directed payments for any class of designated public
19 hospital ~~systems~~, *systems and district and municipal public*
20 *hospitals*, the method for determining the distribution of the
21 directed payment amounts within any class of designated public
22 hospital ~~systems~~, *systems and district and municipal public*
23 *hospitals*, and may modify, consolidate, or subdivide the classes
24 of designated public hospital systems *and district and municipal*
25 *public hospitals* established pursuant to paragraph (1).

26 (D) After the aggregate amounts and the distribution
27 methodology of directed payments for each designated public
28 hospital system *and district and municipal public hospital* class
29 have been established, the department shall consult with the
30 designated public hospital ~~systems~~ *systems, district and municipal*
31 *public hospitals*, and each affected Medi-Cal managed care plan
32 with regard to the impact on the Medi-Cal managed care plan
33 capitation ratesetting process and implementation of the directed
34 payment requirements, including applicable interim and final
35 payment processes, to ensure that 100 percent of the aggregate
36 amounts are paid to the applicable designated public hospital
37 ~~system~~. *system and district and municipal public hospital*.

38 (3) The required directed payment amounts shall be paid by the
39 Medi-Cal managed care plans as adjustments, in a form and manner
40 specified by the department, to the total amounts of contract

1 services payments otherwise paid to the designated public hospital
2 ~~systems~~; *systems and district and municipal public hospitals*.

3 (4) The directed payments required under this subdivision shall
4 be implemented and documented by each Medi-Cal managed care
5 ~~plan and plan~~, designated public hospital ~~system system~~, and
6 *district and municipal public hospital, as applicable*, in accordance
7 with all of the following parameters and any guidance issued by
8 the department:

9 (A) A Medi-Cal managed care plan and the designated public
10 hospital ~~systems and district and municipal public hospitals~~ shall
11 determine the manner, timing, and amount of payment for contract
12 services, including through fee-for-service, capitation, or other
13 permissible manner. The rates of payment for contract services
14 agreed upon by the Medi-Cal managed care plan and the designated
15 public hospital system *and district and municipal public hospital,*
16 *as applicable*, shall be established and documented without regard
17 to the directed payments and quality incentive payments required
18 by this section.

19 (B) The required directed payment enhancements provided
20 pursuant to this subdivision shall not supplant amounts that would
21 otherwise be payable by a Medi-Cal managed care plan to a
22 designated public hospital system *or district and municipal public*
23 *hospital* for an applicable state fiscal year or rate year, and the
24 Medi-Cal managed care plan shall not impose a fee or retention
25 amount that would result in a direct or indirect reduction to the
26 amounts required under this subdivision.

27 (C) A contract between a Medi-Cal managed care plan and a
28 designated public hospital system *or district and municipal public*
29 *hospital* shall not be terminated by either party for the specific
30 purpose of circumventing or otherwise impacting the payment
31 obligations implemented pursuant to this subdivision.

32 (D) If a Medi-Cal managed care plan subcontracts or delegates
33 responsibility to a separate entity for either or both the arrangement
34 or payment of services, the Medi-Cal managed care plan shall be
35 responsible for paying the designated public hospital system *and*
36 *district and municipal public hospital, as applicable*, the directed
37 payment described in this subdivision with respect to the services
38 it provides that are covered by that arrangement. The designated
39 public hospital system *or district and municipal public hospital,*
40 *as applicable*, and the applicable subcontractor or delegated entity

1 shall work together with the Medi-Cal managed care plan to
2 provide the information necessary to facilitate the Medi-Cal
3 managed care plan's compliance with the payment requirements
4 under this subdivision.

5 (5) Each state fiscal year, a Medi-Cal managed care plan shall
6 provide to the department, at the times and in the form and manner
7 specified by the department, an accounting of amounts paid or
8 payable to the designated public hospital systems ~~it contracts with,~~
9 *and district and municipal public hospitals with which it contracts,*
10 including both contract rates and the directed payments, to
11 demonstrate compliance with this subdivision. To the extent *that*
12 the department determines that a Medi-Cal managed care plan is
13 not in compliance with the requirements of this subdivision, or is
14 otherwise circumventing the purposes thereof, to the material
15 detriment of an applicable designated public hospital system, the
16 department may, after providing notice of its determination to the
17 affected Medi-Cal managed care plan and allowing a reasonable
18 period for the Medi-Cal managed care plan to cure the specified
19 deficiencies, reduce the default assignment into the Medi-Cal
20 managed care plan with respect to all Medi-Cal managed care
21 beneficiaries by up to 25 percent in the applicable county, so long
22 as the other Medi-Cal managed care plan or Medi-Cal managed
23 care plans in the applicable county have the capacity to receive
24 the additional default membership. The department's determination
25 whether to exercise discretion under this paragraph shall not be
26 subject to judicial review, except that a Medi-Cal managed care
27 plan that has its default assignment reduced pursuant to this
28 paragraph may bring a writ of mandate under Section 1085 of the
29 Code of Civil Procedure to rectify an abuse of discretion by the
30 department under this paragraph. Nothing in this paragraph shall
31 be construed to preclude or otherwise limit the right of any
32 Medi-Cal managed care plan or designated public hospital system
33 to pursue a breach of contract action, or any other available remedy
34 as appropriate, in connection with the requirements of this
35 subdivision.

36 (6) Capitation rates paid by the department to a Medi-Cal
37 managed care plan shall be actuarially sound and account for the
38 Medi-Cal managed care plan's obligation to pay the directed
39 payments to designated public hospital systems *and district and*
40 *municipal public hospitals* in accordance with this subdivision.

1 The department may require Medi-Cal managed care plans and
2 the designated public hospital systems *and district and municipal*
3 *public hospitals* to submit information regarding contract rates and
4 expected or actual utilization of services, at the times and in the
5 form and manner specified by the department. To the extent
6 consistent with federal law and actuarial standards of practice, the
7 department shall utilize the most recently available data and
8 reasonable projections, as determined by the department, when
9 accounting for the directed payments required under this
10 subdivision, and shall account for additional clinics, practices, or
11 other health care providers added to a designated public hospital
12 ~~system~~. *system or district and municipal public hospital*. In
13 implementing the requirements of this section, including the
14 Medi-Cal managed care plan ratesetting process, the department
15 may additionally account for material adjustments, as appropriate
16 under federal law and actuarial standards, as described above, and
17 as determined by the department, to contracts entered into between
18 a Medi-Cal managed care plan or applicable subcontracted or
19 delegated entity and a designated public hospital ~~system~~. *system*
20 *or district and municipal public hospital, as applicable*.

21 (c) Commencing with the 2017–18 state fiscal year for
22 designated public hospital systems, and commencing with the
23 2020–21 state fiscal year for district and municipal public hospitals,
24 and for each state fiscal year or rate year, as applicable, thereafter,
25 the department, in consultation with the designated public hospital
26 systems, district and municipal public hospitals, and applicable
27 Medi-Cal managed care plans, as applicable, shall establish and
28 implement a program or programs under which a designated public
29 hospital system or a district and municipal public hospital may
30 earn performance-based quality incentive payments from the
31 Medi-Cal managed care plan *with which* they contract ~~with~~ in
32 accordance with this subdivision.

33 (1) Payments shall be earned by each designated public hospital
34 system based on its performance in achieving identified targets
35 for quality of care.

36 (A) The department, in consultation with the designated public
37 hospital systems and applicable Medi-Cal managed care plans,
38 shall establish and provide a method for updating uniform
39 performance measures for the performance-based quality incentive
40 payment program and parameters for the designated public hospital

1 systems to select the applicable measures. The performance
2 measures shall advance at least one goal identified in the state's
3 Medicaid quality strategy. Through and until June 30, 2020,
4 performance measures pursuant to this subdivision shall not
5 duplicate measures utilized in the PRIME program established
6 pursuant to Section 14184.50.

7 (B) Each designated public hospital system shall submit reports
8 to the department containing information required to evaluate its
9 performance on all applicable performance measures, at the times
10 and in the form and manner specified by the department. A
11 Medi-Cal managed care plan shall assist a designated public
12 hospital system in collecting and distributing information necessary
13 for these reports.

14 (2) The department, in consultation with each designated public
15 hospital system, shall determine a maximum amount that each
16 class established pursuant to paragraph (1) of subdivision (b) may
17 earn in quality incentive payments for the state fiscal *year or rate*
18 year.

19 (3) The department shall calculate the amount earned by each
20 designated public hospital system based on its performance score
21 established pursuant to paragraph (1).

22 (A) This amount shall be paid to the designated public hospital
23 system by each of its contracted Medi-Cal managed care plans. If
24 a designated public hospital system contracts with multiple
25 Medi-Cal managed care plans, the department shall identify each
26 Medi-Cal managed care plan's proportionate amount of the
27 designated public hospital system's payment. The timing and
28 amount of the distributions and any related reporting requirements
29 for interim payments shall be established and agreed to by the
30 designated public hospital system and each of the applicable
31 Medi-Cal managed care plans.

32 (B) A contract between a Medi-Cal managed care plan and
33 designated public hospital system shall not be terminated by either
34 party for the specific purpose of circumventing or otherwise
35 impacting the payment obligations implemented pursuant to this
36 subdivision.

37 (C) Each Medi-Cal managed care plan shall be responsible for
38 payment of the quality incentive payments described in this
39 subdivision, subject to funding by the department pursuant to
40 paragraph (5).

1 (4) Commencing with the 2020–21 state fiscal year, payments
2 under this paragraph shall be earned by a district and municipal
3 public hospital based on its performance in achieving identified
4 targets for quality of care.

5 (A) The department, in consultation with district and municipal
6 public hospitals, shall establish a class of district and municipal
7 public hospitals, or multiple classes to the extent federal approval
8 is available, for purposes of payments under this paragraph.

9 (B) The department, in consultation with district and municipal
10 public hospitals, shall determine a maximum amount that the class,
11 or classes, of district and municipal *public* hospitals established
12 pursuant to subparagraph (A) may earn in quality incentive
13 payments for an applicable state fiscal *year or rate* year.

14 (C) The department, in consultation with district and municipal
15 public hospitals and applicable Medi-Cal managed care plans,
16 shall establish and provide a method for updating uniform
17 performance measures for the performance-based quality incentive
18 payments and parameters for district and municipal public hospitals
19 to select the applicable measures. The performance measures shall
20 advance at least one goal identified in the state’s Medicaid quality
21 strategy.

22 (D) Each district and municipal public hospital shall submit
23 reports to the department containing information required to
24 evaluate its performance on all applicable performance measures,
25 at the time and in the form and manner specified by the department.
26 Medi-Cal managed care plans shall assist a district and municipal
27 public hospital in collecting and distributing information necessary
28 for these reports.

29 (E) The department shall calculate the amount earned by each
30 district and municipal public hospital based on its performance
31 score established pursuant to subparagraphs (C) and (D). This
32 amount shall be paid to the district and municipal public hospital
33 by each of its contracted Medi-Cal managed care plans. If a district
34 and municipal public hospital contracts with multiple Medi-Cal
35 managed care plans, the department shall identify each Medi-Cal
36 managed care plan’s proportionate amount of the district and
37 municipal public hospital’s payment. The timing and amount of
38 the distributions and any related reporting requirements for interim
39 payments shall be established and agreed to by the district and

1 municipal public hospital and each of the applicable Medi-Cal
2 managed care plans.

3 (F) A contract between a Medi-Cal managed care plan and
4 district and municipal public hospital shall not be terminated by
5 either party for the specific purpose of circumventing or otherwise
6 impacting the payment obligations implemented pursuant to this
7 paragraph.

8 (G) Each Medi-Cal managed care plan shall be responsible for
9 payment of the quality incentive payments described in this
10 paragraph, subject to funding by the department pursuant to
11 paragraph (5).

12 (5) The department shall provide appropriate funding to each
13 Medi-Cal managed care plan, to account for and to enable them
14 to make the quality incentive payments described in this
15 subdivision, through the incorporation into actuarially sound
16 capitation rates or any other federally permissible method. The
17 amounts designated by the department for the quality incentive
18 payments made pursuant to this subdivision shall be reserved for
19 the purposes of the performance-based quality incentive payment
20 program.

21 (d) (1) In determining the amount of the required directed
22 payments described in paragraph (2) of subdivision (b), and the
23 aggregate size of the quality incentive payment program described
24 in paragraph (2) of subdivision (c), the department shall consult
25 with designated public hospital systems to establish levels for these
26 payments that, in combination with one another, are projected to
27 result in aggregate payments that will advance the quality and
28 access objectives reflected in prior payment enhancement
29 mechanisms for designated public hospital systems. To the extent
30 necessary to meet these objectives or to comply with any federal
31 requirements, the department may, in consultation with the
32 designated public hospital systems, adjust or modify either or both
33 the directed payments or quality incentive payment program. Once
34 these payment levels are established, the department shall consult
35 with the designated public hospital systems and the Medi-Cal
36 managed care plans in the development of the Medi-Cal managed
37 care rates needed for the directed payments and the structure of
38 the quality incentive payment program.

39 (2) (A) For the 2017–18 state fiscal year, the department shall,
40 as soon as practicable after receipt of necessary federal approvals

1 pursuant to paragraph (1) of subdivision (g), provide written notice
2 of the directed payment and quality incentive payment amounts
3 established pursuant to this section. A Medi-Cal managed care
4 plan’s obligation to pay the directed payments and quality incentive
5 payments required under subdivisions (b) and (c), respectively, to
6 a designated public hospital system for the 2017–18 state fiscal
7 year shall be contingent on the receipt of the written notice
8 described in this subparagraph.

9 (B) For each annual determination, commencing with the
10 2018–19 state fiscal year and each state fiscal year or rate year
11 thereafter, the department shall provide written notice, as soon as
12 practicable, to each affected Medi-Cal managed care plan,
13 designated public hospital system, and, commencing with the
14 2020–21 state fiscal year, each district and municipal public
15 hospital of the applicable Medi-Cal managed care plan’s directed
16 payment amounts, the classification of designated public hospital
17 systems and district and municipal public hospitals, as applicable,
18 quality incentive payment amounts, and any other information
19 deemed necessary for the Medi-Cal managed care plan to fulfill
20 its payment obligations under subdivisions (b) and (c), as
21 applicable, for the subject state fiscal *year or rate* year. If the
22 modification of either or both directed payment amounts or quality
23 incentive payment amounts is necessary after receipt of the written
24 notification, the department shall notify the Medi-Cal managed
25 care plan, designated public hospital system, and district and
26 municipal public hospital, as applicable, in writing of the revised
27 amounts before implementation of the revised amounts.

28 (e) (1) The provisions of paragraphs (3), (4), and (5) of
29 subdivision (a), paragraphs (3) and (4) of subdivision (b),
30 paragraphs (3) and (5) of subdivision (c), and paragraph (2) of
31 subdivision (d) shall be deemed incorporated into each contract
32 between a designated public hospital system and a Medi-Cal
33 managed care plan, and its subcontractor or designee, as applicable,
34 and any claim for breach of those provisions may be brought by
35 the designated public hospital system or the Medi-Cal managed
36 care plan directly in a court of competent jurisdiction.

37 (2) Commencing with the 2020–21 state fiscal year, the
38 provisions of paragraph (4) of subdivision (c) and paragraph (2)
39 of subdivision (d) shall be deemed incorporated into each contract
40 between a district and municipal *public* hospital and a Medi-Cal

1 managed care plan, and its subcontractor or designee, as applicable,
 2 and any claim for breach of those provisions may be brought by
 3 the district and municipal public hospital or the Medi-Cal managed
 4 care plan directly in a court of competent jurisdiction.

5 (f) (1) (A) The nonfederal share of the portion of the capitation
 6 rates specifically associated with directed payments to designated
 7 public hospital systems required under subdivision (b) and for the
 8 quality incentive payments established pursuant to subdivision (e),
 9 or associated with quality incentive payments to district and
 10 municipal public hospital systems pursuant to paragraph (4) of
 11 subdivision (e), (c) may consist of voluntary intergovernmental
 12 transfers of funds provided by designated public hospitals or district
 13 and municipal public hospitals and their affiliated governmental
 14 entities, or other public entities, pursuant to Section 14164. Upon
 15 providing any intergovernmental transfer of funds, each transferring
 16 entity shall certify that the transferred funds qualify for federal
 17 financial participation pursuant to applicable federal Medicaid
 18 laws, and in the form and manner specified by the department.
 19 Any intergovernmental transfer of funds made pursuant to this
 20 section shall be considered voluntary for purposes of all federal
 21 laws. ~~Notwithstanding any other law, the department shall not~~
 22 ~~assess the fee described in subdivision (d) of Section 14301.4 or~~
 23 ~~any other similar fee.~~

24 (B) *Notwithstanding any other law, commencing with the 2025*
 25 *calendar year, the department may, upon acceptance of the*
 26 *voluntary intergovernmental transfers described in subparagraph*
 27 *(A), assess a fee not to exceed 5 percent on intergovernmental*
 28 *transfers pursuant to this section to reimburse the department for*
 29 *the administrative costs of operating the programs pursuant to*
 30 *this section and for the support of the Medi-Cal program.*

31 (2) (A) When applicable for voluntary intergovernmental
 32 transfers described in paragraph ~~(1)~~, (1) that are associated with
 33 payments to designated public hospital systems, the department,
 34 in consultation with the designated public hospital systems, shall
 35 develop and maintain a protocol to determine the available funding
 36 for the nonfederal share associated with payments for each
 37 applicable state fiscal year or rate year pursuant to this section.
 38 The protocol developed and maintained pursuant to this paragraph
 39 shall account for any applicable contributions made by public
 40 entities to the nonfederal share of Medi-Cal managed care

1 expenditures, including, but not limited to, contributions previously
2 made by those specific public entities for the 2015–16 state fiscal
3 year pursuant to Section 14182.15 or 14199.2, but excluding any
4 contributions made pursuant to Sections 14301.4 and 14301.5.
5 Nothing in this section shall be construed to limit or otherwise
6 alter any existing authority of the department to accept
7 intergovernmental transfers for purposes of funding the nonfederal
8 share of Medi-Cal managed care expenditures.

9 (B) When applicable for voluntary intergovernmental transfers
10 described in paragraph (1) that are associated with ~~quality incentive~~
11 payments to district and municipal public hospital systems, the
12 department, in consultation with district and municipal public
13 hospital systems, shall develop and maintain a protocol to
14 determine the available funding for the nonfederal share associated
15 with payments for each applicable state fiscal year *or rate year*
16 pursuant to ~~paragraph (4) of subdivision (e): this section~~. Nothing
17 in this section shall be construed to limit or otherwise alter any
18 existing authority of the department to accept intergovernmental
19 transfers for purposes of funding the nonfederal share of Medi-Cal
20 managed care expenditures.

21 (g) (1) This section shall be implemented only to the extent
22 that any necessary federal approvals are obtained and federal
23 financial participation is available and is not otherwise jeopardized.

24 (2) For any state fiscal year in which this section is implemented,
25 in whole or in part, and notwithstanding any other law, the
26 department or a Medi-Cal managed care plan shall not be required
27 to make any payment pursuant to Section 14182.15, 14199.2, or
28 14301.5. Nothing in this section shall be construed to preclude or
29 otherwise impose limitations on payment amounts or arrangements
30 that may be negotiated and agreed to between the relevant parties,
31 including, but not limited to, the continuation of existing or the
32 creation of new quality incentive or pay-for-performance programs
33 in addition to the quality incentive payment program described in
34 subdivision (c) and contract services payments that may be in
35 excess of the directed payment amounts required under subdivision
36 (b).

37 (h) (1) The department shall seek any necessary federal
38 approvals for the directed payments and the quality incentive
39 payments set forth in this section.

1 (2) The department shall consult with the designated public
2 hospital systems *and district and municipal public hospitals* with
3 regard to the development of the directed payment levels
4 established pursuant to ~~subdivision (b)~~ *subdivisions (b) and (c)* of
5 this section, ~~with designated public hospital systems and district~~
6 ~~and municipal public hospitals with regard to the size of the quality~~
7 ~~incentive payments established pursuant to subdivision (c) of this~~
8 ~~section, as applicable,~~ and shall consult with designated public
9 hospital systems, district and municipal *public* hospitals, and
10 Medi-Cal managed care plans with regards to the implementation
11 of payments under this section.

12 (3) The director, after consultation with the designated public
13 hospital ~~systems~~ *systems, district and municipal public hospitals,*
14 and Medi-Cal managed care plans, may modify the requirements
15 set forth in this section to the extent necessary to meet federal
16 requirements or to maximize available federal financial
17 participation. If federal approval is only available with significant
18 limitations or modifications, or if there are changes to the federal
19 Medicaid program that result in a loss of funding currently
20 available to the designated public hospital systems or to the district
21 and municipal public hospitals, the department shall consult with
22 the designated public hospitals ~~system,~~ *systems,* the district and
23 municipal public hospital, *hospitals,* and Medi-Cal managed care
24 plans, as applicable, to consider alternative methodologies.

25 (i) Notwithstanding Chapter 3.5 (commencing with Section
26 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
27 the department may implement, interpret, or make specific this
28 section by means of all-county letters, plan letters, provider
29 bulletins, or other similar instructions, without taking regulatory
30 action. The department shall make use of appropriate processes to
31 ensure that affected designated public hospital systems, the district
32 and municipal public hospitals, and Medi-Cal managed care plans,
33 as applicable, are timely informed of, and have access to, applicable
34 guidance issued pursuant to this authority, and that this guidance
35 remains publicly available until all payments made pursuant to
36 this section are finalized.

37 (j) (1) (A) Directed payments and quality incentive payments
38 to designated public hospital systems pursuant to subdivisions (b)
39 and (c) shall cease to be operative on the first day of the state fiscal
40 year *or rate year* beginning on or after the date the department

1 determines, after consultation with the designated public hospital
2 systems, that implementation of this section is no longer financially
3 ~~and or~~ programmatically supportive of the Medi-Cal program.
4 This determination shall be based solely on ~~both~~ of the following
5 factors:

6 (i) The projected amount of nonfederal share funds available is
7 insufficient to support implementation of the payments to
8 designated public hospital systems pursuant to subdivisions (b)
9 and (c) in the subject state fiscal year or rate year.

10 (ii) The degree to which the payment arrangements for
11 designated public hospital systems will no longer materially
12 advance the goals and objectives reflected in this section and in
13 the department's managed care quality strategy drafted and
14 implemented pursuant to Section 438.340 of Title 42 of the Code
15 of Federal Regulations in the subject state fiscal year or rate year.

16 (B) In making its determination, the department shall consider
17 all reasonable options for mitigating the circumstances set forth
18 in subparagraph (A), including, but not limited to, options for
19 curing projected funding shortfalls and options for program
20 revisions and strategy updates to better coordinate payment
21 requirements with the goals and objectives of this section and the
22 managed care quality strategy.

23 (C) The department shall post notice of the determination on
24 its internet website, and shall provide written notice of the
25 determination to the Secretary of State, the Secretary of the Senate,
26 the Chief Clerk of the Assembly, and the Legislative Counsel.

27 (2) (A) ~~Quality-Directed payments and quality~~ incentive
28 payments to district and municipal public hospitals pursuant to
29 ~~subdivision~~ *subdivisions (b) and (c)* shall cease to be operative on
30 the first day of the state fiscal year *or rate year* beginning on or
31 after the date the department determines, after consultation with
32 the district and municipal public hospitals, that implementation of
33 this section is no longer financially ~~and or~~ programmatically
34 supportive of the Medi-Cal program. This determination shall be
35 based solely on ~~both~~ of the following factors:

36 (i) The projected amount of nonfederal share funds available is
37 insufficient to support implementation of the ~~quality incentive~~
38 payments to district and municipal hospitals pursuant to ~~subdivision~~
39 *subdivisions (b) and (c)* in the subject state fiscal year or rate year.

1 (ii) The degree to which the payment arrangement for district
2 and municipal hospitals will no longer materially advance the goals
3 and objectives reflected in this section and in the department's
4 managed care quality strategy drafted and implemented pursuant
5 to Section 438.340 of Title 42 of the Code of Federal Regulations
6 in the subject state fiscal year or rate year.

7 (B) In making its determination, the department shall consider
8 all reasonable options for mitigating the circumstances set forth
9 in subparagraph (A), including, but not limited to, options for
10 curing projected funding shortfalls and options for program
11 revisions and strategy updates to better coordinate payment
12 requirements with the goals and objectives of this section and the
13 managed care quality strategy.

14 ~~(3) (C) The~~

15 (C) The department shall post notice of the determination on its
16 internet website, and shall provide written notice of the
17 determination to the Secretary of State, the Secretary of the Senate,
18 the Chief Clerk of the Assembly, and the Legislative Counsel.

19 (k) The department, in consultation with the designated public
20 hospital systems and the Medi-Cal managed care plans, shall
21 provide the Legislature with the federally approved evaluation
22 plan required in Section 438.6(c)(2)(i)(D) of Title 42 of the Code
23 of Federal Regulations to measure the degree to which the
24 payments authorized under this section advance at least one of the
25 goals and objectives of the department's managed care quality
26 strategy. The department, in consultation with the designated public
27 hospital systems and the Medi-Cal managed care plans, shall report
28 to the Legislature the results of this evaluation once the department
29 determines that the evaluation is finalized and complete according
30 to the terms of any applicable federal approval and no earlier than
31 January 1, 2021.

32 (l) (1) The department may, after consultation with the
33 designated public hospital systems, the district and municipal
34 public hospitals, and Medi-Cal managed care plans, as applicable,
35 exclude certain Medi-Cal managed care enrollee categories of aid,
36 or subcategories thereof, or certain categories of medical assistance
37 provided under a Medi-Cal managed care plan, or subcategories
38 thereof, from the definition of "contract services payments" for
39 purposes of the directed payment requirements described in
40 subdivision (b).

1 (2) The department shall seek federal approval to implement
2 this subdivision.

3 (m) For purposes of this section, the following definitions apply:

4 (1) “Contract services payments” means the amount paid or
5 payable to a designated public hospital system, including amounts
6 paid or payable under fee-for-service, capitation amounts before
7 any adjustments for service payment withholds or deductions, or
8 payments made on any other basis, under a network provider
9 contract with a Medi-Cal managed care plan for medically
10 necessary and covered services, drugs, supplies, or other items
11 provided to an eligible Medi-Cal beneficiary enrolled in the
12 Medi-Cal managed care plan, excluding services provided to
13 individuals who are dually eligible for both the Medicare and
14 Medi-Cal programs and any additional exclusions that are approved
15 pursuant to subdivision (l). Contract services includes all covered
16 services, drugs, supplies, or other items the designated public
17 hospital system provides, or is responsible for providing, or
18 arranging or paying for, pursuant to a network provider contract
19 entered into with a Medi-Cal managed care plan. If a Medi-Cal
20 managed care plan subcontracts or delegates responsibility to a
21 separate entity for either or both the arrangement or payment of
22 services, “contract services payments” also include amounts paid
23 or payable for the services provided by, or otherwise the
24 responsibility of, the designated public hospital system that are
25 within the scope of services of the subcontracted or delegated
26 arrangement so long as the designated public hospital system holds
27 a network provider contract with the primary Medi-Cal managed
28 care plan.

29 (2) “Designated public hospital” has the same meaning as set
30 forth in subdivision (f) of Section 14184.10.

31 (3) “Designated public hospital system” means a designated
32 public hospital and its affiliated government entity clinics,
33 practices, and other health care providers, including the respective
34 affiliated hospital authority and county government entities
35 described in Chapter 5 (commencing with Section 101850) and
36 Chapter 5.5 (commencing with Section 101852), of Part 4 of
37 Division 101 of the Health and Safety Code.

38 (4) (A) “Medi-Cal managed care plan” means an applicable
39 organization or entity that enters into a contract with the department
40 pursuant to any of the following:

- 1 (i) Article 2.7 (commencing with Section 14087.3).
- 2 (ii) Article 2.8 (commencing with Section 14087.5).
- 3 (iii) Article 2.81 (commencing with Section 14087.96).
- 4 (iv) Article 2.82 (commencing with Section 14087.98).
- 5 (v) Article 2.91 (commencing with Section 14089).
- 6 (vi) Chapter 8 (commencing with Section 14200).

7 (B) “Medi-Cal managed care plan” does not include any of the
8 following:

9 (i) A mental health plan contracting to provide mental health
10 care for Medi-Cal beneficiaries pursuant to Chapter 8.9
11 (commencing with Section 14700).

12 (ii) A plan not covering inpatient services, such as primary care
13 case management plans, operating pursuant to Section 14088.85.

14 (iii) A Program of All-Inclusive Care for the Elderly
15 organization operating pursuant to Chapter 8.75 (commencing
16 with Section 14591).

17 (5) “Network provider” has the same meaning as that term is
18 defined in Section 438.2 of Title 42 of the Code of Federal
19 Regulations, and does not include arrangements where a designated
20 public hospital system or a district and municipal public hospital
21 provides or arranges for services under an agreement intended to
22 cover a specific range of services for a single identified patient for
23 a single inpatient admission, including any directly related followup
24 care, outpatient visit or service, or other similar patient specific
25 nonnetwork contractual arrangement, such as a letter of agreement
26 or single case agreement, with a Medi-Cal managed care plan or
27 subcontractor of a Medi-Cal managed care plan.

28 (6) “District and municipal public hospital” means a
29 nondesignated public hospital, as defined in subdivision (k) of
30 Section 14184.10, that is a contracted network provider of one or
31 more Medi-Cal managed care plans, and that had an approved
32 project plan under the PRIME program established pursuant to
33 Section 14184.50 or is otherwise authorized to participate in a
34 quality incentive directed payment program pursuant to the
35 applicable terms of federal approval obtained by the department
36 pursuant to paragraph (1) of subdivision (h).

37 *SEC. 69. Section 14197.6 is added to the Welfare and*
38 *Institutions Code, to read:*

39 *14197.6. (a) For purposes of this section, the following*
40 *definitions apply:*

1 (1) “Children’s hospital” has the same meaning as that term
2 is defined in Section 10727.

3 (2) “Medi-Cal managed care plan” has the same meaning as
4 that term is defined in subdivision (j) of Section 14184.101.

5 (b) Notwithstanding any other law, for dates of service no sooner
6 than July 1, 2024, the department shall establish a directed
7 payment reimbursement methodology, or revise one or more
8 existing directed payment reimbursement methodologies,
9 applicable to children’s hospitals. Medi-Cal managed care plans
10 shall reimburse children’s hospitals in accordance with the
11 requirements of the directed payment arrangement established by
12 the department pursuant to this section and guidance issued
13 pursuant to subdivision (e).

14 (c) The department shall establish the form and manner of the
15 directed payments authorized pursuant to this section, in
16 consultation with representatives of children’s hospitals and in
17 accordance with the requirements for directed payment
18 arrangements described in Section 438.6(c) of Title 42 of the Code
19 of Federal Regulations and any associated federal guidance.

20 (d) In implementing this section, the department shall seek any
21 federal approvals that it deems necessary. This section shall be
22 implemented only to the extent that any necessary federal approvals
23 are obtained and federal financial participation is available and
24 is not otherwise jeopardized.

25 (e) Notwithstanding the rulemaking provisions of Chapter 3.5
26 (commencing with Section 11340) of Part 1 of Division 3 of Title
27 2 of the Government Code, the department may implement this
28 section, in whole or in part, by means of all-county letters, plan
29 letters, provider bulletins, information notices, or other similar
30 instructions, without taking any further regulatory action.

31 (f) The department shall develop the methodologies and
32 parameters for the payments implemented pursuant to subdivisions
33 (b) and (c) and may revise the methodologies and parameters for
34 purposes, including, but not limited to, obtaining or maintaining
35 any necessary federal approvals as required by subdivision (d).

36 (g) Commencing no sooner than July 1, 2024, and
37 notwithstanding Section 13340 of the Government Code, one
38 hundred fifteen million dollars (\$115,000,000) annually shall be
39 continuously appropriated to the department from the General
40 Fund to support the payments implemented pursuant to this section,

1 *except that such amount may be adjusted pursuant to subdivision*
2 *(h).*

3 *(h) If the Protect Access to Healthcare Act of 2024 (A.G. No.*
4 *23-0024) is approved by the voters, and if children's hospitals*
5 *receive increased reimbursement rates or payments pursuant to*
6 *Section 14199.108, 14199.108.3, 14199.112, or 14199.116, or if*
7 *children's hospitals receive increased reimbursement rates or*
8 *payments funded pursuant to subdivision (c) of Section 14105.200,*
9 *then the amount available for directed payments to children's*
10 *hospitals as specified in subdivision (g) and the amount directed*
11 *pursuant to subdivision (c) may be reduced by the estimated total*
12 *amount of such increases, as determined by the Department of*
13 *Health Care Services, in an amount not to exceed seventy-five*
14 *million dollars (\$75,000,000) annually.*

15 *(i) It is the intent of the Legislature that the payments*
16 *implemented pursuant to this section are to augment amounts that*
17 *would otherwise be payable to children's hospitals by a Medi-Cal*
18 *managed plan or the department. It is not the intent of the*
19 *Legislature that the payments implemented pursuant to this section*
20 *replace amounts that would otherwise be payable by a Medi-Cal*
21 *managed care plan or the department to children's hospitals.*

22 *SEC. 70. Section 14197.7 of the Welfare and Institutions Code,*
23 *as amended by Section 110 of Chapter 790 of the Statutes of 2023,*
24 *is amended to read:*

25 14197.7. (a) Notwithstanding any other law, if the director
26 finds that any entity that contracts with the department for the
27 delivery of health care services (contractor), including a Medi-Cal
28 managed care plan or a prepaid health plan, fails to comply with
29 contract requirements, state or federal law or regulations, or the
30 state plan or approved waivers, or for other good cause, the director
31 may terminate the contract or impose sanctions as set forth in this
32 section. Good cause includes, but is not limited to, a finding of
33 deficiency that results in improper denial or delay in the delivery
34 of health care services, potential endangerment to patient care,
35 disruption in the contractor's provider network, failure to approve
36 continuity of care, that claims accrued or to accrue have not or
37 will not be recompensed, or a delay in required contractor reporting
38 to the department.

39 (b) The director may identify findings of noncompliance or
40 good cause through any means, including, but not limited to,

1 findings in audits, investigations, contract compliance reviews,
2 quality improvement system monitoring, routine monitoring,
3 facility site surveys, encounter and provider data submissions,
4 grievances and appeals, network adequacy reviews, assessments
5 of timely access requirements, reviews of utilization data, health
6 plan rating systems, fair hearing decisions, complaints from
7 beneficiaries and other stakeholders, whistleblowers, and contractor
8 self-disclosures.

9 (c) Except when the director determines that there is an
10 immediate threat to the health of Medi-Cal beneficiaries receiving
11 health care services from the contractor, at the request of the
12 contractor, the department shall hold a public hearing to commence
13 30 days after notice of intent to terminate the contract has been
14 received by the contractor. The department shall present evidence
15 at the hearing showing good cause for the termination. The
16 department shall assign an administrative law judge who shall
17 provide a written recommendation to the department on the
18 termination of the contract within 30 days after conclusion of the
19 hearing. Reasonable notice of the hearing shall be given to the
20 contractor, Medi-Cal beneficiaries receiving services through the
21 contractor, and other interested parties, including any other persons
22 and organizations as the director may deem necessary. The notice
23 shall state the effective date of, and the reason for, the termination.

24 (d) In lieu of contract termination, the director shall have the
25 power and authority to require or impose a plan of correction and
26 issue one or more of the following sanctions against a contractor
27 for findings of noncompliance or good cause, including, but not
28 limited to, those specified in subdivision (a):

29 (1) Temporarily or permanently suspend enrollment and
30 marketing activities.

31 (2) Require the contractor to suspend or terminate contractor
32 personnel or subcontractors.

33 (3) Issue one or more of the temporary suspension orders set
34 forth in subdivision (j).

35 (4) Impose temporary management consistent with the
36 requirements specified in Section 438.706 of Title 42 of the Code
37 of Federal Regulations.

38 (5) Suspend default enrollment of enrollees who do not select
39 a contractor for the delivery of health care services.

1 (6) Impose civil monetary sanctions consistent with the dollar
2 amounts and violations specified in Section 438.704 of Title 42
3 of the Code of Federal Regulations, as follows:

4 (A) A limit of twenty-five thousand dollars (\$25,000) for each
5 determination of the following:

6 (i) The contractor fails to provide medically necessary services
7 that the contractor is required to provide, under law or under its
8 contract with the department, to an enrollee covered under the
9 contract.

10 (ii) The contractor misrepresents or falsifies information to an
11 enrollee, potential enrollee, or health care provider.

12 (iii) The contractor distributes directly, or indirectly through an
13 agent or independent contractor, marketing materials that have not
14 been approved by the state or that contain false or materially
15 misleading information.

16 (B) A limit of one hundred thousand dollars (\$100,000) for each
17 determination of the following:

18 (i) The contractor conducts any act of discrimination against an
19 enrollee on the basis of their health status or need for health care
20 services. This includes termination of enrollment or refusal to
21 reenroll a beneficiary, except as permitted under the Medicaid
22 program, or any practice that would reasonably be expected to
23 discourage enrollment by beneficiaries whose medical condition
24 or history indicates probable need for substantial future medical
25 services.

26 (ii) The contractor misrepresents or falsifies information that it
27 furnishes to the federal Centers for Medicare and Medicaid Services
28 or to the department.

29 (C) A limit of fifteen thousand dollars (\$15,000) for each
30 beneficiary the director determines was not enrolled because of a
31 discriminatory practice under clause (i) of subparagraph (B). This
32 sanction is subject to the overall limit of one hundred thousand
33 dollars (\$100,000) under subparagraph (B).

34 (e) Notwithstanding the monetary sanctions imposed for the
35 violations set forth in paragraph (6) of subdivision (d), the director
36 may impose monetary sanctions in accordance with this section
37 based on any of the following:

38 (1) The contractor violates any federal or state statute or
39 regulation.

1 (2) The contractor violates any provision of its contract with
2 the department.

3 (3) The contractor violates any provision of the state plan or
4 approved waivers.

5 (4) The contractor fails to meet quality metrics or benchmarks
6 established by the department. Any changes to the minimum quality
7 metrics or benchmarks made by the department that are effective
8 on or after January 1, 2020, shall be established in advance of the
9 applicable reporting or performance measurement period, unless
10 required by the federal government.

11 (5) The contractor fails to demonstrate that it has an adequate
12 network to meet anticipated utilization in its service area.

13 (6) The contractor fails to comply with network adequacy
14 standards, including, but not limited to, time and distance, timely
15 access, and provider-to-beneficiary ratio requirements pursuant to
16 standards and formulae that are set forth in federal or state law,
17 regulation, state plan or contract, and that are posted in advance
18 to the department's internet website.

19 (7) The contractor fails to comply with the requirements of a
20 corrective action plan.

21 (8) The contractor fails to submit timely and accurate network
22 provider data.

23 (9) The director identifies deficiencies in the contractor's
24 delivery of health care services.

25 (10) The director identifies deficiencies in the contractor's
26 operations, including the timely payment of claims.

27 (11) The contractor fails to comply with reporting requirements,
28 including, but not limited to, those set forth in Section 53862 of
29 Title 22 of the California Code of Regulations.

30 (12) The contractor fails to timely and accurately process
31 grievances or appeals.

32 (f) (1) Monetary sanctions imposed pursuant to subdivision (e)
33 may be separately and independently assessed and may also be
34 assessed for each day the contractor fails to correct an identified
35 deficiency. For a deficiency that impacts beneficiaries, each
36 beneficiary impacted constitutes a separate violation. Monetary
37 sanctions shall be assessed in the following amounts:

38 (A) Up to twenty-five thousand dollars (\$25,000) for a first
39 violation.

40 (B) Up to fifty thousand dollars (\$50,000) for a second violation.

1 (C) Up to one hundred thousand dollars (\$100,000) for each
2 subsequent violation.

3 (2) For monetary sanctions imposed on a contractor that is
4 funded from one or more of the realigned accounts described in
5 paragraphs (2) to (4), inclusive, of subdivision (n), the department
6 shall calculate a percentage of the funds attributable to the
7 contractor to be offset per month pursuant to paragraphs (2) to (4),
8 inclusive, of subdivision (n) until the amount offset equals the
9 amount of the penalty imposed pursuant to paragraph (1).

10 (g) When assessing sanctions pursuant to this section, the
11 director shall determine the appropriate amount of the penalty for
12 each violation based upon one or more of the following
13 nonexclusive factors:

14 (1) The nature, scope, and gravity of the violation, including
15 the potential harm or impact on beneficiaries.

16 (2) The good or bad faith of the contractor.

17 (3) The contractor's history of violations.

18 (4) The willfulness of the violation.

19 (5) The nature and extent to which the contractor cooperated
20 with the department's investigation.

21 (6) The nature and extent to which the contractor aggravated or
22 mitigated any injury or damage caused by the violation.

23 (7) The nature and extent to which the contractor has taken
24 corrective action to ensure the violation will not recur.

25 (8) The financial status of the contractor, including whether the
26 sanction will affect the ability of the contractor to come into
27 compliance.

28 (9) The financial cost of the health care service that was denied,
29 delayed, or modified.

30 (10) Whether the violation is an isolated incident.

31 (11) The amount of the penalty necessary to deter similar
32 violations in the future.

33 (12) Any other mitigating factors presented by the contractor.

34 (h) Except in exigent circumstances in which there is an
35 immediate risk to the health of beneficiaries, as determined by the
36 department, the director shall give reasonable written notice to the
37 contractor of the intention to impose any of the sanctions authorized
38 by this section and others who may be directly interested, including
39 any other persons and organizations as the director may deem
40 necessary. The notice shall include the effective date for, the

1 duration of, and the reason for each sanction proposed by the
2 director. A contractor may request the department to meet and
3 confer with the contractor to discuss information and evidence that
4 may impact the director's final decision to impose sanctions
5 authorized by this section. The director shall grant a request to
6 meet and confer prior to issuance of a final sanction if the
7 contractor submits the request in writing to the department no later
8 than two business days after the contractor's receipt of the
9 director's notice of intention to impose sanctions.

10 (i) Notwithstanding subdivision (d), the director shall terminate
11 a contract with a contractor that the United States Secretary of
12 Health and Human Services has determined does not meet the
13 requirements for participation in the Medicaid program contained
14 in Subchapter XIX (commencing with Section 1396) of Chapter
15 7 of Title 42 of the United States Code.

16 (j) (1) The department may make one or more of the following
17 temporary suspension orders as an immediate sanction:

18 (A) Temporarily suspend enrollment activities.

19 (B) Temporarily suspend marketing activities.

20 (C) Require the contractor to temporarily suspend specified
21 personnel of the contractor.

22 (D) Require the contractor to temporarily suspend participation
23 by a specified subcontractor.

24 (2) The temporary suspension orders shall be effective no earlier
25 than 20 days after the notice specified in subdivision (k).

26 (k) Prior to issuing a temporary suspension order, or temporarily
27 withholding funds pursuant to subdivision (o), the department shall
28 provide the contractor with a written notice. The notice shall state
29 the department's intent to impose a temporary suspension or
30 temporary withhold, and specify the nature and effective date of
31 the temporary suspension or temporary withhold. The contractor
32 shall have 30 calendar days from the date of receipt of the notice
33 to file a written appeal with the department. Upon receipt of a
34 written appeal filed by the contractor, the department shall, within
35 15 days, set the matter for hearing, which shall be held as soon as
36 possible, but not later than 30 days after receipt of the notice of
37 hearing by the contractor. The hearing may be continued at the
38 request of the contractor if a continuance is necessary to permit
39 presentation of an adequate defense. The temporary suspension
40 order shall remain in effect until the hearing is completed and the

1 department has made a final determination on the merits. However,
2 the temporary suspension order shall be deemed vacated if the
3 director fails to make a final determination on the merits within
4 60 days after the original hearing has been completed. The
5 department shall stay imposition of a temporary withhold, pursuant
6 to subdivision (o), until the hearing is completed and the
7 department has made a final determination on the merits.

8 (l) (1) Except as provided in paragraph (2), a contractor may
9 request a hearing in connection with any sanctions applied pursuant
10 to subdivision (d) or (e) within 15 working days after the notice
11 of the effective date of the sanctions has been given, by sending
12 a letter so stating to the address specified in the notice. The
13 department shall stay collection of monetary sanctions upon receipt
14 of the request for a hearing. Collection of the sanction shall remain
15 stayed until the effective date of the final decision of the
16 department.

17 (2) With respect to mental health plans, the due process and
18 appeals process specified in paragraph (4) of subdivision (b) of
19 Section 14718 shall be made available in connection with any
20 contract termination actions, temporary suspension orders,
21 temporary withholds of funds pursuant to subdivision (o), and
22 sanctions applied pursuant to subdivision (d) or (e).

23 (m) Except as otherwise provided in this section, all hearings
24 to review the imposition of sanctions, including temporary
25 suspension orders, the withholding or offsetting of funds pursuant
26 to subdivision (n), or the temporary withholding of funds pursuant
27 to subdivision (o), shall be held pursuant to the procedures set
28 forth in Section 100171 of the Health and Safety Code.

29 (n) (1) If the director imposes monetary sanctions pursuant to
30 this section on a contractor, except for a contractor described in
31 paragraphs (2) to (4), inclusive, the amount of the sanction may
32 be collected by withholding the amount from capitation or other
33 associated payments owed to the contractor.

34 (2) If the director imposes monetary sanctions on a contractor
35 that is funded from the Mental Health Subaccount, the Mental
36 Health Equity Subaccount, the Vehicle License Collection Account
37 of the Local Revenue Fund, or the Mental Health Account, the
38 director may offset the monetary sanctions from the respective
39 account. The offset is subject to paragraph (2) of subdivision (q).

1 (3) If the director imposes monetary sanctions on a contractor
2 that is funded from the Behavioral Health Subaccount of the Local
3 Revenue Fund 2011, the director may offset the monetary sanctions
4 from that account from the distribution attributable to the applicable
5 contractor. The offset is subject to paragraph (2) of subdivision
6 (q).

7 (4) If the director imposes monetary sanctions on a contractor
8 that is funded from any other mental health or substance use
9 disorder realignment funds from which the Controller is authorized
10 to make distributions to the contractor, the director may offset the
11 monetary sanctions from these funds if the funds described in
12 paragraphs (2) and (3) are insufficient for the purposes described
13 in this subdivision, as appropriate. The offset is subject to
14 paragraph (2) of subdivision (q).

15 (o) (1) Whenever the department determines that a mental
16 health plan or any entity that contracts with the department to
17 provide Drug Medi-Cal services has violated state or federal law,
18 a requirement of this chapter, Chapter 8 (commencing with Section
19 14200), Chapter 8.8 (commencing with Section 14600), or Chapter
20 8.9 (commencing with Section 14700), or any regulations, the state
21 plan, or a term or condition of an approved waiver, or a provision
22 of its contract with the department, the department may temporarily
23 withhold payments of federal financial participation and payments
24 from the accounts listed in paragraphs (2) to (4), inclusive, of
25 subdivision (n). The department shall temporarily withhold
26 amounts it deems necessary to ensure the mental health plan or
27 the entity that contracts with the department to provide Drug
28 Medi-Cal services promptly corrects the violation. The department
29 shall release the temporarily withheld funds when it determines
30 the mental health plan or the entity that contracts with the
31 department to provide Drug Medi-Cal services has come into
32 compliance.

33 (2) A mental health plan, or any entity that contracts with the
34 department to provide Drug Medi-Cal services, may appeal the
35 imposition of a temporary withhold pursuant to this subdivision
36 in accordance with the procedures described in subdivisions (k)
37 and (m). Imposition of a temporary withhold shall be stayed until
38 the effective date of the final decision of the department.

39 (p) This section shall be read in conjunction with, and apply in
40 addition to, any other applicable law that authorizes the department

1 to impose sanctions or otherwise take remedial action upon
2 contractors.

3 (q) (1) (A) Notwithstanding any other law, nonfederal moneys
4 collected by the department pursuant to this section, except for
5 moneys collected from a contractor funded from one or more of
6 the realigned accounts described in paragraphs (2) to (4), inclusive,
7 of subdivision (n), shall be deposited into the General Fund for
8 use, and upon appropriation by the Legislature, to address
9 workforce issues in the Medi-Cal program and to improve access
10 to care in the Medi-Cal program.

11 (B) *Beginning July 1, 2024, and continuing until June 30, 2027,*
12 *unless otherwise specified in law, nonfederal moneys collected by*
13 *the department pursuant to this section, except for moneys collected*
14 *from a contractor funded from one or more of the realigned*
15 *accounts described in paragraphs (2) to (4), inclusive, of*
16 *subdivision (n), shall be deposited into the General Fund for use*
17 *and, upon appropriation by the Legislature, for the nonfederal*
18 *share of Medi-Cal costs for health care services furnished to*
19 *children, adults, seniors, and persons with disabilities, and persons*
20 *dually eligible for the Medi-Cal program and the Medicare*
21 *Program.*

22 (2) Monetary sanctions imposed via offset on a contractor that
23 is funded from one or more of the realigned accounts described in
24 paragraphs (2) to (4), inclusive, of subdivision (n) shall be
25 redeposited into the account from which the monetary sanctions
26 were offset pursuant to paragraphs (2) to (4), inclusive, of
27 subdivision (n). The department shall notify the Department of
28 Finance of the percentage reduction for the affected county. The
29 Department of Finance shall subsequently notify the Controller,
30 and the Controller shall redistribute the monetary sanction amount
31 to nonsanctioned counties based on each county's prorated share
32 of the monthly base allocations from the realigned account. With
33 respect to an individual contractor, the department shall not collect
34 via offset more than 25 percent of the total amount of the funds
35 distributed from the applicable account or accounts that are
36 attributable to the contractor in a given month. If the department
37 is not able to collect the full amount of monetary sanctions imposed
38 on a contractor funded from one or more of the realigned accounts
39 described in paragraphs (2) to (4), inclusive, of subdivision (n) in
40 a given month, the department shall continue to offset the amounts

1 attributable to the contractor in subsequent months until the full
2 amount of monetary sanctions has been collected.

3 (r) (1) Notwithstanding Chapter 3.5 (commencing with Section
4 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
5 the department may implement, interpret, or make specific this
6 section, in whole or in part, by means of plan or county letters,
7 information notices, plan or provider bulletins, or other similar
8 instructions, without taking any further regulatory action.

9 (2) By July 1, 2025, the department shall adopt any regulations
10 necessary to implement this section in accordance with the
11 requirements of Chapter 3.5 (commencing with Section 11340) of
12 Part 1 of Division 3 of Title 2 of the Government Code.

13 (s) This section shall be implemented only to the extent that any
14 necessary federal approvals have been obtained and that federal
15 financial participation is available.

16 (t) For purposes of this section, “contractor” means any
17 individual, organization, or entity that enters into a contract with
18 the department to provide services to enrolled Medi-Cal
19 beneficiaries pursuant to any of the following:

20 (1) Article 2.7 (commencing with Section 14087.3), including
21 dental managed care programs developed pursuant to Section
22 14087.46.

23 (2) Article 2.8 (commencing with Section 14087.5).

24 (3) Article 2.81 (commencing with Section 14087.96).

25 (4) Article 2.82 (commencing with Section 14087.98).

26 (5) Article 2.9 (commencing with Section 14088).

27 (6) Article 2.91 (commencing with Section 14089).

28 (7) Chapter 8 (commencing with Section 14200), including
29 dental managed care plans.

30 (8) Chapter 8.9 (commencing with Section 14700).

31 (9) A county Drug Medi-Cal organized delivery system
32 authorized under the California Medi-Cal 2020 Demonstration
33 pursuant to Article 5.5 (commencing with Section 14184) or a
34 successor demonstration or waiver, as applicable.

35 (u) If amendments to the Mental Health Services Act are
36 approved by the voters at the March 5, 2024, statewide primary
37 election, this section shall become inoperative on January 1, 2025,
38 and as of that date is repealed.

1 *SEC. 71. Section 14197.7 of the Welfare and Institutions Code,*
2 *as added by Section 111 of Chapter 790 of the Statutes of 2023,*
3 *is amended to read:*

4 14197.7. (a) (1) Notwithstanding any other law, if the director
5 finds that an entity that contracts with the department for the
6 delivery of health care services (contractor), including a Medi-Cal
7 managed care plan or a prepaid health plan, fails to comply with
8 contract requirements, state or federal law or regulations, or the
9 state plan or approved waivers, or for other good cause, the director
10 may terminate the contract or impose sanctions as set forth in this
11 section.

12 (2) Good cause includes, but is not limited to, a finding of
13 deficiency that results in improper denial or delay in the delivery
14 of health care services, potential endangerment to patient care,
15 disruption in the contractor's provider network, failure to approve
16 continuity of care, that claims accrued or to accrue have not or
17 will not be recompensed, or a delay in required contractor reporting
18 to the department.

19 (b) The director may identify findings of noncompliance or
20 good cause through any means, including, but not limited to,
21 findings in audits, investigations, contract compliance reviews,
22 quality improvement system monitoring, routine monitoring,
23 facility site surveys, encounter and provider data submissions,
24 grievances and appeals, network adequacy reviews, assessments
25 of timely access requirements, reviews of utilization data, health
26 plan rating systems, fair hearing decisions, complaints from
27 beneficiaries and other stakeholders, whistleblowers, and contractor
28 self-disclosures.

29 (c) (1) Except when the director determines there is an
30 immediate threat to the health of Medi-Cal beneficiaries receiving
31 health care services from the contractor, at the request of the
32 contractor, the department shall hold a public hearing to commence
33 30 days after notice of intent to terminate the contract has been
34 received by the contractor.

35 (2) The department shall present evidence at the hearing showing
36 good cause for the termination.

37 (3) The department shall assign an administrative law judge
38 who shall provide a written recommendation to the department on
39 the termination of the contract within 30 days after conclusion of
40 the hearing.

1 (4) (A) Reasonable notice of the hearing shall be given to the
2 contractor, Medi-Cal beneficiaries receiving services through the
3 contractor, and other interested parties, including any other person
4 and organization the director may deem necessary.

5 (B) The notice shall state the effective date of, and the reason
6 for, the termination.

7 (d) In lieu of contract termination, the director shall have the
8 power and authority to require or impose a plan of correction and
9 issue one or more of the following sanctions against a contractor
10 for findings of noncompliance or good cause, including, but not
11 limited to, those specified in subdivision (a):

12 (1) Temporarily or permanently suspend enrollment and
13 marketing activities.

14 (2) Require the contractor to suspend or terminate contractor
15 personnel or subcontractors.

16 (3) Issue one or more of the temporary suspension orders set
17 forth in subdivision (j).

18 (4) Impose temporary management consistent with the
19 requirements specified in Section 438.706 of Title 42 of the Code
20 of Federal Regulations.

21 (5) Suspend default enrollment of enrollees who do not select
22 a contractor for the delivery of health care services.

23 (6) Impose civil monetary sanctions consistent with the dollar
24 amounts and violations specified in Section 438.704 of Title 42
25 of the Code of Federal Regulations, as follows:

26 (A) A limit of twenty-five thousand dollars (\$25,000) for each
27 determination of the following:

28 (i) The contractor fails to provide medically necessary services
29 that the contractor is required to provide, under law or under its
30 contract with the department, to an enrollee covered under the
31 contract.

32 (ii) The contractor misrepresents or falsifies information to an
33 enrollee, potential enrollee, or health care provider.

34 (iii) The contractor distributes directly, or indirectly through an
35 agent or independent contractor, marketing materials that have not
36 been approved by the state or that contain false or materially
37 misleading information.

38 (B) A limit of one hundred thousand dollars (\$100,000) for each
39 determination of the following:

1 (i) The contractor conducts an act of discrimination against an
2 enrollee on the basis of their health status or need for health care
3 services. This includes termination of enrollment or refusal to
4 reenroll a beneficiary, except as permitted under the Medicaid
5 program, or a practice that would reasonably be expected to
6 discourage enrollment by beneficiaries whose medical condition
7 or history indicates probable need for substantial future medical
8 services.

9 (ii) The contractor misrepresents or falsifies information that it
10 furnishes to the federal Centers for Medicare and Medicaid Services
11 or to the department.

12 (C) A limit of fifteen thousand dollars (\$15,000) for each
13 beneficiary the director determines was not enrolled because of a
14 discriminatory practice under clause (i) of subparagraph (B). This
15 sanction is subject to the overall limit of one hundred thousand
16 dollars (\$100,000) under subparagraph (B).

17 (e) Notwithstanding the monetary sanctions imposed for the
18 violations set forth in paragraph (6) of subdivision (d), the director
19 may impose monetary sanctions in accordance with this section
20 based on any of the following:

21 (1) The contractor violates a federal or state statute or regulation.

22 (2) The contractor violates a provision of its contract with the
23 department.

24 (3) The contractor violates a provision of the state plan or
25 approved waivers.

26 (4) The contractor fails to meet quality metrics or benchmarks
27 established by the department. Any changes to the minimum quality
28 metrics or benchmarks made by the department that are effective
29 on or after January 1, 2020, shall be established in advance of the
30 applicable reporting or performance measurement period, unless
31 required by the federal government.

32 (5) The contractor fails to demonstrate that it has an adequate
33 network to meet anticipated utilization in its service area.

34 (6) The contractor fails to comply with network adequacy
35 standards, including, but not limited to, time and distance, timely
36 access, and provider-to-beneficiary ratio requirements pursuant to
37 standards and formulae that are set forth in federal or state law,
38 regulation, state plan, or contract and that are posted in advance
39 to the department's internet website.

1 (7) The contractor fails to comply with the requirements of a
2 corrective action plan.

3 (8) The contractor fails to submit timely and accurate network
4 provider data.

5 (9) The director identifies deficiencies in the contractor's
6 delivery of health care services.

7 (10) The director identifies deficiencies in the contractor's
8 operations, including the timely payment of claims.

9 (11) The contractor fails to comply with reporting requirements,
10 including, but not limited to, those set forth in Section 53862 of
11 Title 22 of the California Code of Regulations.

12 (12) The contractor fails to timely and accurately process
13 grievances or appeals.

14 (f) (1) Monetary sanctions imposed pursuant to subdivision (e)
15 may be separately and independently assessed and may also be
16 assessed for each day the contractor fails to correct an identified
17 deficiency. For a deficiency that impacts beneficiaries, each
18 beneficiary impacted constitutes a separate violation. Monetary
19 sanctions shall be assessed in the following amounts:

20 (A) Up to twenty-five thousand dollars (\$25,000) for a first
21 violation.

22 (B) Up to fifty thousand dollars (\$50,000) for a second violation.

23 (C) Up to one hundred thousand dollars (\$100,000) for each
24 subsequent violation.

25 (2) For monetary sanctions imposed on a contractor that is
26 funded from one or more of the realigned accounts described in
27 paragraphs (2) to (4), inclusive, of subdivision (n), the department
28 shall calculate a percentage of the funds attributable to the
29 contractor to be offset per month pursuant to paragraphs (2) to (4),
30 inclusive, of subdivision (n) until the amount offset equals the
31 amount of the penalty imposed pursuant to paragraph (1).

32 (g) When assessing sanctions pursuant to this section, the
33 director shall determine the appropriate amount of the penalty for
34 each violation based upon one or more of the following
35 nonexclusive factors:

36 (1) The nature, scope, and gravity of the violation, including
37 the potential harm or impact on beneficiaries.

38 (2) The good or bad faith of the contractor.

39 (3) The contractor's history of violations.

40 (4) The willfulness of the violation.

- 1 (5) The nature and extent to which the contractor cooperated
2 with the department's investigation.
- 3 (6) The nature and extent to which the contractor aggravated or
4 mitigated any injury or damage caused by the violation.
- 5 (7) The nature and extent to which the contractor has taken
6 corrective action to ensure the violation will not recur.
- 7 (8) The financial status of the contractor, including whether the
8 sanction will affect the ability of the contractor to come into
9 compliance.
- 10 (9) The financial cost of the health care service that was denied,
11 delayed, or modified.
- 12 (10) Whether the violation is an isolated incident.
- 13 (11) The amount of the penalty necessary to deter similar
14 violations in the future.
- 15 (12) Other mitigating factors presented by the contractor.
- 16 (h) (1) Except in exigent circumstances in which there is an
17 immediate risk to the health of beneficiaries, as determined by the
18 department, the director shall give reasonable written notice to the
19 contractor of the intention to impose any of the sanctions authorized
20 by this section and others who may be directly interested, including
21 any other persons and organizations the director may deem
22 necessary.
- 23 (2) The notice shall include the effective date for, the duration
24 of, and the reason for each sanction proposed by the director.
- 25 (3) A contractor may request the department to meet and confer
26 with the contractor to discuss information and evidence that may
27 impact the director's final decision to impose sanctions authorized
28 by this section.
- 29 (4) The director shall grant a request to meet and confer prior
30 to issuance of a final sanction if the contractor submits the request
31 in writing to the department no later than two business days after
32 the contractor's receipt of the director's notice of intention to
33 impose sanctions.
- 34 (i) Notwithstanding subdivision (d), the director shall terminate
35 a contract with a contractor that the United States Secretary of
36 Health and Human Services has determined does not meet the
37 requirements for participation in the Medicaid program contained
38 in Subchapter XIX (commencing with Section 1396) of Chapter
39 7 of Title 42 of the United States Code.

- 1 (j) (1) The department may make one or more of the following
2 temporary suspension orders as an immediate sanction:
- 3 (A) Temporarily suspend enrollment activities.
 - 4 (B) Temporarily suspend marketing activities.
 - 5 (C) Require the contractor to temporarily suspend specified
6 personnel of the contractor.
 - 7 (D) Require the contractor to temporarily suspend participation
8 by a specified subcontractor.
- 9 (2) The temporary suspension orders shall be effective no earlier
10 than 20 days after the notice specified in subdivision (k).
- 11 (k) (1) Prior to issuing a temporary suspension order, or
12 temporarily withholding funds pursuant to subdivision (o), the
13 department shall provide the contractor with a written notice.
- 14 (2) The notice shall state the department's intent to impose a
15 temporary suspension or temporary withhold and specify the nature
16 and effective date of the temporary suspension or temporary
17 withhold.
- 18 (3) The contractor shall have 30 calendar days from the date of
19 receipt of the notice to file a written appeal with the department.
- 20 (4) Upon receipt of a written appeal filed by the contractor, the
21 department shall, within 15 days, set the matter for hearing, which
22 shall be held as soon as possible but not later than 30 days after
23 receipt of the notice of hearing by the contractor.
- 24 (5) The hearing may be continued at the request of the contractor
25 if a continuance is necessary to permit presentation of an adequate
26 defense.
- 27 (6) The temporary suspension order shall remain in effect until
28 the hearing is completed and the department has made a final
29 determination on the merits. However, the temporary suspension
30 order shall be deemed vacated if the director fails to make a final
31 determination on the merits within 60 days of the close of the
32 record for the matter.
- 33 (7) The department shall stay imposition of a temporary
34 withhold, pursuant to subdivision (o), until the hearing is completed
35 and the department has made a final determination on the merits
36 within 60 days of the close of the record for the matter.
- 37 (l) (1) A contractor may request a hearing in connection with
38 sanctions applied pursuant to subdivision (d) or (e) within 15
39 working days after the notice of the effective date of the sanctions

1 has been given by sending a letter so stating to the address specified
2 in the notice.

3 (2) The department shall stay collection of monetary sanctions
4 upon receipt of the request for a hearing.

5 (3) Collection of the sanction shall remain stayed until the
6 effective date of the final decision of the department.

7 (m) Except as otherwise provided in this section, all hearings
8 to review the imposition of sanctions, including temporary
9 suspension orders, the withholding or offsetting of funds pursuant
10 to subdivision (n), or the temporary withholding of funds pursuant
11 to subdivision (o) shall be held pursuant to the procedures set forth
12 in Section 100171 of the Health and Safety Code.

13 (n) (1) If the director imposes monetary sanctions pursuant to
14 this section on a contractor, except for a contractor described in
15 paragraphs (2) to (5), inclusive, the amount of the sanction may
16 be collected by withholding the amount from capitation or other
17 associated payments owed to the contractor.

18 (2) If the director imposes monetary sanctions on a contractor
19 that is funded from the Mental Health Subaccount, the Mental
20 Health Equity Subaccount, the Vehicle License Collection Account
21 of the Local Revenue Fund, or the Mental Health Account, the
22 director may offset the monetary sanctions from the respective
23 account. The offset is subject to paragraph (2) of subdivision (q).

24 (3) If the director imposes monetary sanctions on a contractor
25 that is funded from the Behavioral Health Subaccount of the Local
26 Revenue Fund 2011, the director may offset the monetary sanctions
27 from that account from the distribution attributable to the applicable
28 contractor. The offset is subject to paragraph (2) of subdivision
29 (q).

30 (4) If the director imposes monetary sanctions on a contractor
31 that is funded from another mental health or substance use disorder
32 realignment fund from which the Controller is authorized to make
33 distributions to the contractor, the director may offset the monetary
34 sanctions from these funds if the funds described in paragraphs
35 (2) and (3) are insufficient for the purposes described in this
36 subdivision, as appropriate. The offset is subject to paragraph (2)
37 of subdivision (q).

38 (5) (A) If the director imposes monetary sanctions pursuant to
39 subdivision (e) of Section 5963.04, the director may offset the

1 monetary sanctions from the Behavioral Health Services Fund
2 from the distribution attributable to the applicable contractor.

3 (B) With respect to an individual contractor, the department
4 shall not collect via offset more than 25 percent of the total amount
5 of the funds distributed from the Behavioral Health Services Fund
6 that are attributable to the contractor in a given month.

7 (C) If the department is not able to collect the full amount of
8 monetary sanctions imposed on a contractor in a given month, the
9 department shall continue to offset the amounts attributable to the
10 contractor in subsequent months until the full amount of monetary
11 sanctions has been collected. The offset is subject to paragraph (3)
12 of subdivision (q).

13 (o) (1) (A) Whenever the department determines that a mental
14 health plan or an entity that contracts with the department to
15 provide Drug Medi-Cal services has violated state or federal law,
16 a requirement of this chapter, Chapter 8 (commencing with Section
17 14200), Chapter 8.8 (commencing with Section 14600), or Chapter
18 8.9 (commencing with Section 14700), or any regulations, the state
19 plan, a term or condition of an approved waiver, or a provision of
20 its contract with the department, the department may temporarily
21 withhold payments of federal financial participation and payments
22 from the accounts listed in paragraphs (2) to (4), inclusive, of
23 subdivision (n).

24 (B) The department shall temporarily withhold amounts it deems
25 necessary to ensure the mental health plan or the entity that
26 contracts with the department to provide Drug Medi-Cal services
27 promptly corrects the violation.

28 (C) The department shall release the temporarily withheld funds
29 when it determines the mental health plan or the entity that
30 contracts with the department to provide Drug Medi-Cal services
31 has come into compliance.

32 (2) (A) A mental health plan or an entity that contracts with
33 the department to provide Drug Medi-Cal services may appeal the
34 imposition of a temporary withhold pursuant to this subdivision
35 in accordance with the procedures described in subdivisions (k)
36 and (m).

37 (B) Imposition of a temporary withhold shall be stayed until
38 the effective date of the final decision of the department.

39 (p) This section shall be read in conjunction with, and apply in
40 addition to, any other applicable law that authorizes the department

1 to impose sanctions or otherwise take remedial action upon
2 contractors.

3 (q) (1) (A) Notwithstanding any other law, nonfederal moneys
4 collected by the department pursuant to this section, except for
5 moneys collected from a contractor funded from one or more of
6 the realigned accounts described in paragraphs (2) to (4), inclusive,
7 of subdivision (n), shall be deposited into the General Fund for
8 use and, upon appropriation by the Legislature, to address
9 workforce issues in the Medi-Cal program and improve access to
10 care in the Medi-Cal program.

11 (B) *Beginning July 1, 2024, and continuing until June 30, 2027,*
12 *unless otherwise specified in law, nonfederal moneys collected by*
13 *the department pursuant to this section, except for moneys collected*
14 *from a contractor funded from one or more of the realigned*
15 *accounts described in paragraphs (2) to (4), inclusive, of*
16 *subdivision (n), shall be deposited into the General Fund for use*
17 *and, upon appropriation by the Legislature, for the nonfederal*
18 *share of Medi-Cal costs for health care services furnished to*
19 *children, adults, seniors, and persons with disabilities, and persons*
20 *dually eligible for the Medi-Cal program and the Medicare*
21 *Program.*

22 (2) (A) Monetary sanctions imposed via offset on a contractor
23 that is funded from one or more of the realigned accounts described
24 in paragraphs (2) to (4), inclusive, of subdivision (n) shall be
25 redeposited into the account from which the monetary sanctions
26 were offset pursuant to paragraphs (2) to (4), inclusive, of
27 subdivision (n).

28 (B) The department shall notify the Department of Finance of
29 the percentage reduction for the affected county.

30 (C) The Department of Finance shall subsequently notify the
31 Controller, and the Controller shall redistribute the monetary
32 sanction amount to nonsanctioned counties based on each county's
33 prorated share of the monthly base allocations from the realigned
34 account.

35 (D) With respect to an individual contractor, the department
36 shall not collect via offset more than 25 percent of the total amount
37 of the funds distributed from the applicable account or accounts
38 that are attributable to the contractor in a given month.

39 (E) If the department is not able to collect the full amount of
40 monetary sanctions imposed on a contractor funded from one or

1 more of the realigned accounts described in paragraphs (2) to (4),
2 inclusive, of subdivision (n) in a given month, the department shall
3 continue to offset the amounts attributable to the contractor in
4 subsequent months until the full amount of monetary sanctions
5 has been collected.

6 (3) Monetary sanctions imposed via offset on a contractor
7 pursuant to subdivision (e) of Section 5963.04 shall be redeposited
8 into the account from which the monetary sanctions were offset
9 pursuant to paragraph (5) of subdivision (n).

10 (r) Notwithstanding Chapter 3.5 (commencing with Section
11 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
12 the department may implement, interpret, or make specific this
13 section, in whole or in part, by means of plan or county letters,
14 information notices, plan or provider bulletins, or other similar
15 instructions without taking any further regulatory action.

16 (s) This section shall be implemented only to the extent that
17 necessary federal approvals have been obtained and that federal
18 financial participation is available.

19 (t) For purposes of this section, “contractor” means an
20 individual, organization, or entity that enters into a contract with
21 the department to provide services to enrolled Medi-Cal
22 beneficiaries or other individuals receiving behavioral health
23 services, as applicable, pursuant to any of the following:

24 (1) Article 2.7 (commencing with Section 14087.3), including
25 dental managed care programs developed pursuant to Section
26 14087.46.

27 (2) Article 2.8 (commencing with Section 14087.5).

28 (3) Article 2.81 (commencing with Section 14087.96).

29 (4) Article 2.82 (commencing with Section 14087.98).

30 (5) Article 2.9 (commencing with Section 14088).

31 (6) Article 2.91 (commencing with Section 14089).

32 (7) Chapter 8 (commencing with Section 14200), including
33 dental managed care plans.

34 (8) Chapter 8.9 (commencing with Section 14700).

35 (9) A county Drug Medi-Cal organized delivery system
36 authorized under the California Medi-Cal 2020 Demonstration
37 pursuant to Article 5.5 (commencing with Section 14184) or a
38 successor demonstration or waiver, as applicable.

39 (10) Chapter 2 (commencing with Section 5650) of Part 2 of
40 Division 5, solely for purposes of imposition of corrective action

1 plans, monetary sanctions, or temporary withholds pursuant to
2 subdivision (e) of Section 5963.04.

3 (11) Section 12534 of the Government Code.

4 (u) This section shall become operative on January 1, 2025, if
5 amendments to the Mental Health Services Act are approved by
6 the voters at the March 5, 2024, statewide primary election.

7 *SEC. 72. Section 14199.72 of the Welfare and Institutions Code*
8 *is amended to read:*

9 14199.72. (a) Upon appropriation by the Legislature of funds
10 for this purpose, the department shall establish a clinic workforce
11 stabilization retention payment program to provide funds to eligible
12 qualified clinics to make retention payments to their eligible
13 employees for the public purposes specified in Section 14199.70.
14 ~~To the extent any appropriated funds remain after the department~~
15 ~~has distributed funds to eligible qualified clinics for employee~~
16 ~~retention payments pursuant to this article, those excess funds shall~~
17 ~~be used for qualified clinic workforce training as specified in~~
18 ~~subdivision (h).~~

19 (b) The department shall determine the conditions and data
20 reporting requirements for qualified clinics to be eligible to receive
21 funds. Within 90 days of the effective date of the act that added
22 this article, the department shall notify all qualified clinics of those
23 conditions and requirements, as well as the relevant portions of
24 this article, including, but not limited to, the date of record set by
25 the department, the information qualified clinics are required to
26 submit pursuant to subdivision (c), the methodology for calculation
27 of funds to be distributed pursuant to subdivision (d), how to pay
28 retention payments pursuant to subdivision (e), and the
29 consequences of noncompliance pursuant to Section 14199.74.

30 (c) (1) Each qualified clinic that intends to request funding shall
31 submit the following information to the department no later than
32 30 days after the date of record:

33 (A) The name and mailing address of each eligible employee.

34 (B) The employee’s professional license, certification, or
35 registration, if applicable.

36 (C) Any other information as required by the department for
37 purposes of implementing this article.

38 (2) The possession of a professional license, certification, or
39 registration is not required for an employee to be eligible for a

1 payment. All eligible employees, as defined in subdivision (c) of
2 Section 14199.71, are eligible to receive payments.

3 (3) The information required by this section shall include an
4 attestation, made under penalty of perjury, that the qualified clinic
5 employee did not receive funds pursuant to the Hospital and Skilled
6 Nursing Facility COVID-19 Retention Pay program set forth in
7 Part 4.6 (commencing with Section 1490) of Division 2 of the
8 Labor Code.

9 (d) The department shall distribute funds to each eligible
10 qualified clinic based on the total number of eligible employees
11 reported pursuant to subdivision (c). The amount of the payment
12 shall be up to one thousand dollars (\$1,000) per eligible employee,
13 subject to available funding, and reduced on a pro rata basis if the
14 requests exceed the amount of funds available. The department
15 may distribute these funds to eligible qualified clinics using the
16 existing Medi-Cal Checkwrite system.

17 (e) Within 60 days of receipt of funds from the department, a
18 qualified clinic shall pay eligible employees a retention payment
19 in the amount of up to one thousand dollars (\$1,000) if no pro rata
20 reduction is made pursuant to subdivision (d), or the pro rata
21 reduced amount if a pro rata reduction is made pursuant to
22 subdivision (d). An eligible employee who leaves employment
23 between the date of record and the date a qualified clinic pays
24 retention payments shall not be eligible for retention payments.
25 Each qualified clinic that receives funds shall attest, in a form and
26 manner specified by the department, and under penalty of perjury,
27 that all funding received pursuant to this section, with the exception
28 of any funding requested for eligible employees who left
29 employment after the date of record, was provided to eligible
30 employees within 60 days of receipt from the department. Each
31 qualified clinic that receives funds shall immediately return to the
32 department any funding received pursuant to this section that is
33 not distributed within the timeline set forth in this subdivision,
34 including funds that the department provided for eligible employees
35 who left employment after the date of record.

36 (f) The department shall post on its internet website the amount
37 each clinic site received, and the total number of eligible employees
38 reported by each clinic pursuant to subdivision (c).

1 (g) A qualified clinic shall not use retention payment funding
2 to supplant other payments from the qualified clinic to eligible
3 employees.

4 ~~(h) Upon the order of the Director of Finance, any retention
5 payment funding returned pursuant to subdivision (e) or
6 unexpended funds left over from the appropriation included for
7 this purpose in Item 4260-101-0001 of the Budget Act of 2022
8 after issuance of funding pursuant to subdivision (d), shall be
9 transferred to Item 4140-101-0001 and shall be available for
10 expenditure or encumbrance through June 30, 2028, to fund
11 workforce development programs that support primary care in
12 clinics, which may include teaching health center residency
13 programs, the State Loan Repayment Program, the Allied
14 Healthcare Scholarship Program, the Allied Healthcare Loan
15 Repayment Program, nurse practitioner postgraduate workforce
16 training slots, or physician assistant postgraduate workforce
17 training slots.~~

18 *SEC. 73. Section 14705 of the Welfare and Institutions Code*
19 *is amended to read:*

20 14705. (a) (1) This section shall apply to specialty mental
21 health services provided by counties to Medi-Cal eligible
22 individuals. Counties shall provide services to Medi-Cal
23 beneficiaries and seek the maximum federal reimbursement
24 possible for services rendered to persons with mental illnesses.

25 (2) To the extent permitted under federal law and Section 5892,
26 funds distributed to the counties from the Mental Health
27 Subaccount, the Mental Health Equity Subaccount, and the Vehicle
28 License Collection Account of the Local Revenue Fund, funds
29 from the Mental Health Account and the Behavioral Health
30 Subaccount of the Local Revenue Fund 2011, funds from the
31 ~~Mental Behavioral~~ Health Services Fund, and any other funds
32 from which the Controller makes distributions to the counties may
33 be used to pay for services provided by these funds that the counties
34 can then certify as public expenditures in order to achieve the
35 maximum federal reimbursement possible for services pursuant
36 to this chapter.

37 (3) The standards and guidelines for the administration of
38 specialty mental health services to Medi-Cal eligible persons shall
39 be consistent with federal Medicaid requirements, as specified in
40 the approved Medicaid state plan and waivers to ensure full and

1 timely federal reimbursement to counties for services that are
2 rendered and claimed consistent with federal Medicaid
3 requirements.

4 (b) With regard to each person receiving specialty mental health
5 services from a mental health plan, the mental health plan shall
6 verify whether the person is Medi-Cal eligible and, if determined
7 to be Medi-Cal eligible, the person shall be referred when
8 appropriate to a facility, clinic, or program that is certified for
9 Medi-Cal reimbursement.

10 (c) With regard to county operated facilities, clinics, or programs
11 for which claims are submitted to the department for Medi-Cal
12 reimbursement for specialty mental health services to Medi-Cal
13 eligible individuals, the county shall ensure that all requirements
14 necessary for Medi-Cal reimbursement for these services are
15 complied with, including, but not limited to, utilization review and
16 the submission of yearend cost reports by December 31 following
17 the close of the fiscal year.

18 (d) Counties shall certify to the state that they have incurred
19 public expenditures prior to requesting the reimbursement of
20 federal funds.

21 ~~(e) This section shall become operative on July 1, 2012.~~

22 *SEC. 74. Section 15832 of the Welfare and Institutions Code,*
23 *as amended by Section 162 of Chapter 42 of the Statutes of 2023,*
24 *is amended to read:*

25 15832. (a) To be eligible to participate in the program, a person
26 shall meet all of the requirements in either paragraph (1) or (2):

27 (1) (A) ~~Be a woman who is pregnant or in her~~ *the* postpartum
28 period as specified in Section 15840 and ~~who is~~ a resident of the
29 state. A person who is a member of a federally recognized
30 California Indian tribe is a resident of the state for these purposes.

31 (B) Have a household income that is above 208 percent of the
32 official federal poverty level but does not exceed 317 percent of
33 the official federal poverty level.

34 (C) Agree to the payment of the complete subscriber
35 contribution. A federally recognized California Indian tribal
36 government may make the subscriber contributions on behalf of
37 a member of the tribe only if a contribution on behalf of members
38 of federally recognized California Indian tribes does not limit or
39 preclude federal financial participation under Title XXI of the
40 Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally

1 recognized California Indian tribal government makes a
2 contribution on behalf of a member of the tribe, the tribal
3 government shall ensure that the subscriber is made aware of all
4 the health care delivery options available in the county where the
5 member resides.

6 (2) (A) Be a child under two years of age who is delivered by
7 a mother enrolled in the program under this chapter. Except as
8 stated in this section, these infants shall be automatically enrolled
9 in the program.

10 (B) For the applicable month, not be enrolled in
11 employer-sponsored health care coverage, or have been enrolled
12 in that health care coverage in the prior three months or enrolled
13 in full-scope Medi-Cal without a share of cost. Exceptions may
14 be identified in regulations or other guidance and shall, at
15 minimum, include all exceptions applicable to the Healthy Families
16 Program on and after March 23, 2010.

17 (C) Be subject to subscriber contributions as determined by the
18 department.

19 (3) For infants identified in paragraph (2), all of the following
20 shall apply:

21 (A) Enrollment in the program shall cover the first 12 months
22 of the infant's life unless the infant is determined eligible for
23 Medi-Cal benefits under Section 14005.26. An infant shall be
24 screened for eligibility under Section 14005.26 immediately after
25 the infant is born. If the infant is eligible under Section 14005.26,
26 the infant shall be automatically enrolled in the Medi-Cal program
27 on that basis.

28 (B) (i) At the end of the 12 months, as a condition of continued
29 eligibility, the subscriber shall provide income information. The
30 infant shall be disenrolled from the program if the annual household
31 income exceeds 317 percent of the federal poverty level, or if the
32 infant is eligible for full-scope Medi-Cal with no share of cost.

33 (ii) Effective January 1, 2014, when determining eligibility for
34 benefits under the program, income shall be determined, counted,
35 and valued in accordance with the requirements of Section
36 1397bb(b)(1)(B) of Title 42 of the United States Code as added
37 by the federal Patient Protection and Affordable Care Act (Public
38 Law 111-148) and as amended by the federal Health Care and
39 Education Reconciliation Act of 2010 (Public Law 111-152) and
40 any subsequent amendments.

1 (C) At the end of their first and second year in the program,
2 infants shall be screened for eligibility for the Medi-Cal program.

3 (4) If at any time the director determines that the eligibility
4 criteria established under this chapter for the program may
5 jeopardize the state's ability to receive federal financial
6 participation under the federal Patient Protection and Affordable
7 Care Act (Public Law 111-148), any amendment or extension of
8 that act, or any similar federal legislation affecting federal financial
9 participation, the director may alter the eligibility criteria to the
10 extent necessary for the state to receive that federal financial
11 participation.

12 (5) (A) Effective July 1, 2024, or the effective date for
13 implementation of the Children's Presumptive Eligibility Program
14 portal pursuant to Section 14011.7, whichever is later, all qualified
15 Medi-Cal providers participating in presumptive eligibility
16 programs shall use the electronic Newborn Hospital Gateway
17 process, as described in Section 14148.04, to report the birth of
18 an infant eligible under this chapter who is born in their facilities,
19 including hospitals, birthing centers, or other birthing settings,
20 within 72 hours after the birth, or one business day after discharge,
21 whichever is sooner.

22 (B) The inclusion of infants eligible under this chapter in the
23 Newborn Hospital Gateway process shall commence on July 1,
24 2024, or on the effective date for implementation of the Children's
25 Presumptive Eligibility Program portal pursuant to Section
26 14011.7, whichever is later.

27 (b) ~~If~~ (1) *If the voters approve the addition of Chapter 7.5*
28 *(commencing with Section 14199.100) to Part 3 of this division at*
29 *the November 5, 2024, statewide general election and the*
30 *conditions described in paragraph (1) of subdivision (b) of Section*
31 *15832, as added by Section 137 of the act that added this*
32 *subdivision, have been met, this section shall become inoperative*
33 *on January 1, 2025, or the date certified by the department pursuant*
34 *to paragraph (2) of subdivision (b) of Section 15832, as added by*
35 *Section 137 of the act that added this subdivision, whichever is*
36 *later, and shall be repealed on January 1 directly following that*
37 *date.*

38 (2) *If the voters do not approve the addition of Chapter 7.5*
39 *(commencing with Section 14199.100) to Part 3 of this division at*
40 *the November 5, 2024, statewide general election and the*

1 conditions described in paragraph (1) of subdivision (b) of Section
 2 15832, as added by Section 137 of the act that added this
 3 subdivision, have been met, this section shall become inoperative
 4 on January 1, 2026, or the date certified by the department
 5 pursuant to paragraph (2) of subdivision (b) of Section 15832, as
 6 added by Section 137 of the act that added this subdivision,
 7 whichever is later; and shall be repealed on January 1 directly
 8 following that date.

9 SEC. 75. Section 15832 of the Welfare and Institutions Code,
 10 as amended by Section 163 of Chapter 42 of the Statutes of 2023,
 11 is amended to read:

12 15832. (a) To be eligible to participate in the program, a person
 13 shall meet all of the requirements in either paragraph (1) or (2):

14 (1) (A) ~~Be a person who is pregnant or in the postpartum period~~
 15 ~~as specified in Section 15840 and who is a resident of the state. A~~
 16 ~~person who is a member of a federally recognized California Indian~~
 17 ~~tribe is a resident of the state for these purposes.~~

18 (B) Have a household income that is above 208 percent of the
 19 official federal poverty level but does not exceed 317 percent of
 20 the official federal poverty level.

21 (C) Agree to the payment of the complete subscriber
 22 contribution. A federally recognized California Indian tribal
 23 government may make the subscriber contributions on behalf of
 24 a member of the tribe only if a contribution on behalf of members
 25 of federally recognized California Indian tribes does not limit or
 26 preclude federal financial participation under Title XXI of the
 27 Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally
 28 recognized California Indian tribal government makes a
 29 contribution on behalf of a member of the tribe, the tribal
 30 government shall ensure that the subscriber is made aware of all
 31 the health care delivery options available in the county where the
 32 member resides.

33 (2) (A) Be a child under two years of age who is delivered by
 34 a mother enrolled in the program under this chapter. Except as
 35 stated in this section, these infants shall be automatically enrolled
 36 in the program.

37 (B) For the applicable month, not be enrolled in
 38 employer-sponsored health care coverage, or have been enrolled
 39 in that health care coverage in the prior three months or enrolled
 40 in full-scope Medi-Cal without a share of cost. Exceptions may

1 be identified in regulations or other guidance and shall, at
2 minimum, include all exceptions applicable to the Healthy Families
3 Program on and after March 23, 2010.

4 (C) Be subject to subscriber contributions as determined by the
5 department.

6 (3) For infants identified in paragraph (2), all of the following
7 shall apply:

8 (A) Enrollment in the program shall cover the first 12 months
9 of the infant's life unless the infant is determined eligible for
10 Medi-Cal benefits under Section 14005.26. An infant shall be
11 screened for eligibility under Section 14005.26 immediately after
12 the infant is born. If the infant is eligible under Section 14005.26,
13 the infant shall be automatically enrolled in the Medi-Cal program
14 on that basis.

15 (B) (i) At the end of the 12 months, the infant shall remain
16 continuously eligible for the Medi-Cal program until they are five
17 years of age. A redetermination of Medi-Cal eligibility shall not
18 be conducted before the child reaches five years of age, except as
19 specified in Section 14005.255. This clause shall be implemented
20 to the extent that any necessary federal approvals are obtained and
21 federal financial participation is available. The department shall
22 seek any necessary federal approvals to implement this clause.

23 (ii) Effective January 1, 2014, when determining eligibility for
24 benefits under the program, income shall be determined, counted,
25 and valued in accordance with the requirements of Section
26 1397bb(b)(1)(B) of Title 42 of the United States Code as added
27 by the federal Patient Protection and Affordable Care Act (Public
28 Law 111-148) and as amended by the federal Health Care and
29 Education Reconciliation Act of 2010 (Public Law 111-152) and
30 any subsequent amendments.

31 (C) At the end of their first and second year in the program, and
32 subsequent years, up to five years of age, the child shall be screened
33 for eligibility for the Medi-Cal program.

34 (4) If at any time the director determines that the eligibility
35 criteria established under this chapter for the program may
36 jeopardize the state's ability to receive federal financial
37 participation under the federal Patient Protection and Affordable
38 Care Act (Public Law 111-148), any amendment or extension of
39 that act, or any similar federal legislation affecting federal financial
40 participation, the director may alter the eligibility criteria to the

1 extent necessary for the state to receive that federal financial
2 participation.

3 (5) (A) Effective July 1, 2024, or the effective date for
4 implementation of the Children’s Presumptive Eligibility Program
5 portal pursuant to Section 14011.7, whichever is later, all qualified
6 Medi-Cal providers participating in presumptive eligibility
7 programs shall use the electronic Newborn Hospital Gateway
8 process, as described in Section 14148.04, to report the birth of
9 an infant eligible under this chapter who is born in their facilities,
10 including hospitals, birthing centers, or other birthing settings,
11 within 72 hours after the birth, or one business day after discharge,
12 whichever is sooner.

13 (B) The inclusion of infants eligible under this chapter in the
14 Newborn Hospital Gateway process shall commence on July 1,
15 2024, or on the effective date for implementation of the Children’s
16 Presumptive Eligibility Program portal pursuant to Section
17 14011.7, whichever is later.

18 (b) (1) Implementation of this section is contingent on all of
19 the following conditions:

20 (A) All necessary federal approvals have been obtained by the
21 department pursuant to subdivision (d).

22 (B) The Legislature has appropriated funding to implement this
23 section after a determination that ongoing General Fund resources
24 are available to support the ongoing implementation of this section
25 in the 2024–25 fiscal year and subsequent fiscal years.

26 (C) The department has determined that systems have been
27 programmed to implement this section.

28 (2) The department shall issue a declaration certifying the date
29 that all conditions in paragraph (1) have been met. The department
30 shall post the declaration on its internet website and provide a copy
31 of the declaration to the Secretary of State, the Secretary of the
32 Senate, the Chief Clerk of the Assembly, and the Legislative
33 Counsel.

34 (c) Notwithstanding Chapter 3.5 (commencing with Section
35 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
36 the department may implement, interpret, or make specific this
37 section, in whole or in part, through all-county letters or similar
38 instructions, without taking any further regulatory action.

1 (d) This section shall be implemented only to the extent that
2 any necessary federal approvals are obtained, and federal financial
3 participation is available and not otherwise jeopardized.

4 (e) ~~This~~ (1) *If the voters approve the addition of Chapter 7.5*
5 *(commencing with Section 14199.100) to Part 3 of this division at*
6 *the November 5, 2024, statewide general election, this section*
7 *shall become operative on January 1, 2025, or the date certified*
8 *by the department pursuant to paragraph (2) of subdivision (b),*
9 *whichever is later.*

10 (2) *If the voters do not approve the addition of Chapter 7.5*
11 *(commencing with Section 14199.100) to Part 3 of this division at*
12 *the November 5, 2024, statewide general election, this section*
13 *shall be repealed as of January 1, 2025.*

14 SEC. 76. *Section 15832 is added to the Welfare and Institutions*
15 *Code, to read:*

16 15832. (a) *To be eligible to participate in the program, a*
17 *person shall meet all of the requirements in either paragraph (1)*
18 *or (2):*

19 (1) (A) *Be pregnant or in the postpartum period as specified in*
20 *Section 15840 and a resident of the state. A person who is a*
21 *member of a federally recognized California Indian tribe is a*
22 *resident of the state for these purposes.*

23 (B) *Have a household income that is above 208 percent of the*
24 *official federal poverty level but does not exceed 317 percent of*
25 *the official federal poverty level.*

26 (C) *Agree to the payment of the complete subscriber*
27 *contribution. A federally recognized California Indian tribal*
28 *government may make the subscriber contributions on behalf of*
29 *a member of the tribe only if a contribution on behalf of members*
30 *of federally recognized California Indian tribes does not limit or*
31 *preclude federal financial participation under Title XXI of the*
32 *Social Security Act (42 U.S.C. Sec. 1397aa et seq.). If a federally*
33 *recognized California Indian tribal government makes a*
34 *contribution on behalf of a member of the tribe, the tribal*
35 *government shall ensure that the subscriber is made aware of all*
36 *the health care delivery options available in the county where the*
37 *member resides.*

38 (2) (A) *Be a child under two years of age who is delivered by a*
39 *mother enrolled in the program under this chapter. Except as*

1 *stated in this section, these infants shall be automatically enrolled*
2 *in the program.*

3 *(B) For the applicable month, not be enrolled in*
4 *employer-sponsored health care coverage, or have been enrolled*
5 *in that health care coverage in the prior three months or enrolled*
6 *in full-scope Medi-Cal without a share of cost. Exceptions may be*
7 *identified in regulations or other guidance and shall, at minimum,*
8 *include all exceptions applicable to the Healthy Families Program*
9 *on and after March 23, 2010.*

10 *(C) Be subject to subscriber contributions as determined by the*
11 *department.*

12 *(3) For infants identified in paragraph (2), all of the following*
13 *shall apply:*

14 *(A) Enrollment in the program shall cover the first 12 months*
15 *of the infant's life unless the infant is determined eligible for*
16 *Medi-Cal benefits under Section 14005.26. An infant shall be*
17 *screened for eligibility under Section 14005.26 immediately after*
18 *the infant is born. If the infant is eligible under Section 14005.26,*
19 *the infant shall be automatically enrolled in the Medi-Cal program*
20 *on that basis.*

21 *(B) (i) At the end of the 12 months, the infant shall remain*
22 *continuously eligible for the Medi-Cal program until they are five*
23 *years of age. A redetermination of Medi-Cal eligibility shall not*
24 *be conducted before the child reaches five years of age, except as*
25 *specified in Section 14005.255. This clause shall be implemented*
26 *to the extent that any necessary federal approvals are obtained*
27 *and federal financial participation is available. The department*
28 *shall seek any necessary federal approvals to implement this*
29 *clause.*

30 *(ii) Effective January 1, 2014, when determining eligibility for*
31 *benefits under the program, income shall be determined, counted,*
32 *and valued in accordance with the requirements of Section*
33 *1397bb(b)(1)(B) of Title 42 of the United States Code as added by*
34 *the federal Patient Protection and Affordable Care Act (Public*
35 *Law 111-148) and as amended by the federal Health Care and*
36 *Education Reconciliation Act of 2010 (Public Law 111-152) and*
37 *any subsequent amendments.*

38 *(C) At the end of their first and second year in the program,*
39 *and subsequent years, up to five years of age, the child shall be*
40 *screened for eligibility for the Medi-Cal program.*

1 (4) If at any time the director determines that the eligibility
2 criteria established under this chapter for the program may
3 jeopardize the state's ability to receive federal financial
4 participation under the federal Patient Protection and Affordable
5 Care Act (Public Law 111-148), any amendment or extension of
6 that act, or any similar federal legislation affecting federal
7 financial participation, the director may alter the eligibility criteria
8 to the extent necessary for the state to receive that federal financial
9 participation.

10 (5) (A) Effective July 1, 2024, or the effective date for
11 implementation of the Children's Presumptive Eligibility Program
12 portal pursuant to Section 14011.7, whichever is later, all qualified
13 Medi-Cal providers participating in presumptive eligibility
14 programs shall use the electronic Newborn Hospital Gateway
15 process, as described in Section 14148.04, to report the birth of
16 an infant eligible under this chapter who is born in their facilities,
17 including hospitals, birthing centers, or other birthing settings,
18 within 72 hours after the birth, or one business day after discharge,
19 whichever is sooner.

20 (B) The inclusion of infants eligible under this chapter in the
21 Newborn Hospital Gateway process shall commence on July 1,
22 2024, or on the effective date for implementation of the Children's
23 Presumptive Eligibility Program portal pursuant to Section
24 14011.7, whichever is later.

25 (b) (1) Implementation of this section is contingent on both of
26 the following conditions:

27 (A) All necessary federal approvals have been obtained by the
28 department pursuant to subdivision (d).

29 (B) The department has determined that systems have been
30 programmed to implement this section.

31 (2) The department shall issue a declaration certifying the date
32 that all conditions in paragraph (1) have been met. The department
33 shall post the declaration on its internet website and provide a
34 copy of the declaration to the Secretary of State, the Secretary of
35 the Senate, the Chief Clerk of the Assembly, and the Legislative
36 Counsel.

37 (c) Notwithstanding Chapter 3.5 (commencing with Section
38 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
39 the department may implement, interpret, or make specific this

1 *section, in whole or in part, through all-county letters or similar*
 2 *instructions, without taking any further regulatory action.*

3 *(d) This section shall be implemented only to the extent that any*
 4 *necessary federal approvals are obtained, and federal financial*
 5 *participation is available and not otherwise jeopardized.*

6 *(e) (1) If the voters do not approve the addition of Chapter 7.5*
 7 *(commencing with Section 14199.100) to Part 3 of this division at*
 8 *the November 5, 2024, statewide general election, this section*
 9 *shall become operative on January 1, 2026, or the date certified*
 10 *by the department pursuant to paragraph (2) of subdivision (b),*
 11 *whichever is later.*

12 *(2) If the voters approve the addition of Chapter 7.5*
 13 *(commencing with Section 14199.100) to Part 3 of this division at*
 14 *the November 5, 2024, statewide general election, this section is*
 15 *repealed as of January 1, 2025.*

16 *SEC. 77. Section 15840 of the Welfare and Institutions Code,*
 17 *as amended by Section 138 of Chapter 47 of the Statutes of 2022,*
 18 *is amended to read:*

19 15840. (a) (1) At a minimum, coverage provided pursuant to
 20 this chapter shall be provided to subscribers during one pregnancy,
 21 and until the end of the month in which the 60th day after
 22 pregnancy occurs, and to eligible children less than two years of
 23 age who were born of a pregnancy covered under this program or
 24 the Access for Infants and Mothers program under former Part 6.3
 25 (commencing with Section 12695) of Division 2 of the Insurance
 26 Code to a woman enrolled in the Access for Infants and Mothers
 27 program.

28 (2) (A) Upon the effective date reflected in any necessary
 29 federal approvals obtained by the department pursuant to
 30 subdivision (c) of Section 14005.185, a subscriber described in
 31 paragraph (1) shall be eligible for an additional 10-month period
 32 following the 60-day postpartum period, for a total of 12 months
 33 of continuous eligibility after the end of pregnancy.

34 (B) This paragraph shall be implemented only if, and to the
 35 extent that, any necessary federal approvals are obtained pursuant
 36 to Section 14005.185 and federal financial participation is
 37 available, and subject to an annual appropriation by the Legislature
 38 for this purpose.

39 (b) Coverage provided pursuant to this chapter shall include, at
 40 a minimum, those services required to be provided by health care

1 service plans approved by the Secretary of Health and Human
2 Services as a federally qualified health care service plan pursuant
3 to Section 417.101 of Title 42 of the Code of Federal Regulations.

4 (c) Medically necessary prescription drugs shall be a required
5 benefit in the coverage provided pursuant to this chapter.

6 (d) To the extent required pursuant to Section 15818 to comply
7 with paragraph (1) of subdivision (b) of Section 30122 of the
8 Revenue and Taxation Code, health education services related to
9 tobacco use shall be a benefit in the coverage provided under this
10 chapter.

11 (e) (1) *If the voters approve the addition of Chapter 7.5*
12 *(commencing with Section 14199.100) to Part 3 of this division at*
13 *the November 5, 2024, statewide general election, and the*
14 *conditions described in paragraph (1) of subdivision (b) of Section*
15 *15832, as added by Section 137 of the act that added this*
16 *subdivision, have been met, this section shall become inoperative*
17 *on January 1, 2025, or the date certified by the department pursuant*
18 *to paragraph (2) of subdivision (b) of Section 15832, as added by*
19 *Section 137 of the act that added this subdivision, whichever is*
20 *later, and shall be repealed on January 1 directly following that*
21 *date.*

22 (2) *If the voters do not approve the addition of Chapter 7.5*
23 *(commencing with Section 14199.100) to Part 3 of this division at*
24 *the November 5, 2024, statewide general election, and the*
25 *conditions described in paragraph (1) of subdivision (b) of Section*
26 *15832, as added by Section 137 of the act that added this*
27 *subdivision, have been met, this section shall become inoperative*
28 *on January 1, 2026, or the date certified by the department*
29 *pursuant to paragraph (2) of subdivision (b) of Section 15832, as*
30 *added by Section 137 of the act that added this subdivision,*
31 *whichever is later, and shall be repealed on January 1 directly*
32 *following that date.*

33 *SEC. 78. Section 15840 of the Welfare and Institutions Code,*
34 *as added by Section 137 of Chapter 47 of the Statutes of 2022, is*
35 *amended to read:*

36 15840. (a) (1) At a minimum, coverage provided pursuant to
37 this chapter shall be provided to subscribers during one pregnancy,
38 and until the end of the month in which the 60th day after
39 pregnancy occurs, and to eligible children less than two years of
40 age, or less than five years of age pursuant to Section 15832, who

1 were born of a pregnancy covered under this program or the Access
2 for Infants and Mothers program under former Part 6.3
3 (commencing with Section 12695) of Division 2 of the Insurance
4 Code to a person enrolled in the Access for Infants and Mothers
5 program.

6 (2) (A) Upon the effective date reflected in any necessary
7 federal approvals obtained by the department pursuant to
8 subdivision (c) of Section 14005.185, a subscriber described in
9 paragraph (1) shall be eligible for an additional 10-month period
10 following the 60-day postpartum period, for a total of 12 months
11 of continuous eligibility after the end of pregnancy.

12 (B) This paragraph shall be implemented only if, and to the
13 extent that, any necessary federal approvals are obtained pursuant
14 to Section 14005.185 and federal financial participation is
15 available, and subject to an annual appropriation by the Legislature
16 for this purpose.

17 (b) Coverage provided pursuant to this chapter shall include, at
18 a minimum, those services required to be provided by health care
19 service plans approved by the Secretary of Health and Human
20 Services as a federally qualified health care service plan pursuant
21 to Section 417.101 of Title 42 of the Code of Federal Regulations.

22 (c) Medically necessary prescription drugs shall be a required
23 benefit in the coverage provided pursuant to this chapter.

24 (d) To the extent required pursuant to Section 15818 to comply
25 with paragraph (1) of subdivision (b) of Section 30122 of the
26 Revenue and Taxation Code, health education services related to
27 tobacco use shall be a benefit in the coverage provided under this
28 chapter.

29 (e) ~~This~~ (1) *If the voters approve the addition of Chapter 7.5*
30 *(commencing with Section 14199.100) to Part 3 of this division at*
31 *the November 5, 2024, statewide general election, this section*
32 *shall become operative on January 1, 2025, or the date certified*
33 *by the department pursuant to paragraph (2) of subdivision (b) of*
34 *Section 15832, as added by Section 137 of the act that added this*
35 *subdivision, whichever is later, and shall be repealed on January*
36 *1 directly following that date.*

37 (2) *If the voters do not approve the addition of Chapter 7.5*
38 *(commencing with Section 14199.100) to Part 3 of this division at*
39 *the November 5, 2024, statewide general election, this section*
40 *shall become operative on January 1, 2026, or the date certified*

1 *by the department pursuant to paragraph (2) of subdivision (b) of*
2 *Section 15832, as added by Section 137 of the act that added this*
3 *subdivision, whichever is later, and shall be repealed on January*
4 *1 directly following that date.*

5 *SEC. 79. Section 15853 of the Welfare and Institutions Code,*
6 *as amended by Section 20 of Chapter 738 of the Statutes of 2022,*
7 *is amended to read:*

8 15853. (a) (1) An applicant that will provide an
9 intergovernmental transfer may submit a proposal to the department
10 for funding for the purpose of providing comprehensive health
11 insurance coverage to any child who meets citizenship and
12 immigration status requirements that are applicable to persons
13 participating in the program established by Title XXI of the Social
14 Security Act, and whose family income is at or below 317 percent
15 of the federal poverty level or, at the option of the applicant, at or
16 below 411 percent of the federal poverty level, in specific
17 geographic areas, as published quarterly in the Federal Register
18 by the United States Department of Health and Human Services,
19 as determined, counted and valued in accordance with the
20 requirements of Section 1396a(e)(14) of Title 42 of the United
21 States Code, as added by the federal Patient Protection and
22 Affordable Care Act (Public Law 111-148) and as amended by
23 the federal Health Care and Education Reconciliation Act of 2010
24 (Public Law 111-152) and any subsequent amendments, and which
25 child meets both of the following requirements:

26 (A) Does not qualify for the optional targeted low-income
27 children group or the Access program.

28 (B) Does not qualify for Medi-Cal with no share of cost pursuant
29 to Chapter 7 (commencing with Section 14000) of Part 3.

30 (2) In its application, the applicant shall specify the income
31 level at or below 411 percent of the federal poverty level for which
32 it will provide coverage.

33 (3) The intergovernmental transfer amount is limited to the
34 expenditures which would be eligible for federal financial
35 participation.

36 (b) The proposal shall guarantee at least one year of
37 intergovernmental transfer funding by the applicant at a level that
38 ensures compliance with the requirements of any applicable
39 approved federal waiver or state plan amendment as well as the
40 department's requirements for the sound operation of the proposed

1 project, and shall, on an annual basis, either commit to fully
2 funding the necessary intergovernmental amount or withdraw from
3 the program. The department may identify specific geographical
4 areas that, compared to the national level, have a higher cost of
5 living or housing or a greater need for additional health services,
6 using data obtained from the most recent federal census, the federal
7 Consumer Expenditure Survey, or from other sources. The proposal
8 may include an administrative mechanism for outreach and
9 eligibility.

10 (c) The applicant may include in its proposal reimbursement of
11 medical, dental, vision, or mental health services delivered to
12 children who are eligible under the Access program or under the
13 Medi-Cal program as an optional targeted low-income children
14 group beneficiary, if these services are part of an overall program
15 with the measurable goal of enrolling served children in the Access
16 program or the optional targeted low-income children group.

17 (d) If a child is determined to be eligible for benefits for the
18 treatment of an eligible medical condition under the California
19 Children's Services Program pursuant to Article 5 (commencing
20 with Section 123800) of Chapter 3 of Part 2 of Division 106 of
21 the Health and Safety Code, the health, dental, or vision plan
22 providing services to the child pursuant to this chapter shall not
23 be responsible for the provision of, or payment for, those authorized
24 services for that child. The proposal from an applicant shall contain
25 provisions to ensure that a child whom the health, dental, or vision
26 plan reasonably believes would be eligible for services under the
27 California Children's Services Program is referred to that program.
28 The California Children's Services Program shall provide case
29 management and authorization of services if the child is found to
30 be eligible for the California Children's Services Program.
31 Diagnosis and treatment services that are authorized by the
32 California Children's Services Program shall be performed by
33 paneled providers for that program and approved special care
34 centers of that program and approved by the California Children's
35 Services Program. All other services provided under the proposal
36 from the applicant shall be made available pursuant to this chapter
37 to a child who is eligible for services under the California
38 Children's Services Program.

39 (e) Notwithstanding any other provision of this section, an
40 applicant may submit a proposal to the department for the purposes

1 of providing comprehensive health insurance coverage to children
2 whose coverage is not eligible for funding under Title XXI of the
3 Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a
4 combination of children whose coverage is eligible for funding
5 under Title XXI of the Social Security Act and children whose
6 coverage is not eligible for that funding. To be approved by the
7 department, these proposals shall comply with both of the following
8 requirements:

9 (1) Meet all applicable requirements for funding under this
10 chapter, except for availability of funding through Title XXI of
11 the Social Security Act.

12 (2) Provide for the administration of children’s coverage by the
13 department through the administrative infrastructure serving the
14 Medi-Cal program, and through health care service plans serving
15 the Medi-Cal program.

16 (f) Implementation of this section is conditioned on the
17 department obtaining necessary federal approval of these
18 provisions.

19 (g) Notwithstanding any other provision of this part, the status
20 of any application previously submitted to, and approved by, the
21 Managed Risk Medical Insurance Board pursuant to former Part
22 6.4 (commencing with Section 12699.50) of Division 2 of the
23 Insurance Code shall not be altered as a result of the assumption
24 by the department, pursuant to this chapter, of the responsibilities
25 previously exercised by the Managed Risk Medical Insurance
26 Board.

27 (h) ~~(1) If the voters approve the addition of Chapter 7.5~~
28 ~~(commencing with Section 14199.100) to Part 3 of this division at~~
29 ~~the November 5, 2024, statewide general election, and the~~
30 ~~conditions described in paragraph (1) of subdivision (k) of Section~~
31 ~~15853, as added by Section 21 of the act that added this~~
32 ~~subdivision, have been met, this section shall become inoperative~~
33 ~~on January 1, 2025, or the date certified by the department pursuant~~
34 ~~to paragraph (2) of subdivision (k) of Section 15853, as added by~~
35 ~~Section 21 of the act that added this subdivision, whichever is~~
36 ~~later, and shall be repealed on January 1 directly following that~~
37 ~~date.~~

38 (2) *If the voters do not approve the addition of Chapter 7.5*
39 *(commencing with Section 14199.100) to Part 3 of this division at*
40 *the November 5, 2024, statewide general election, and the*

1 conditions described in paragraph (1) of subdivision (k) of Section
2 15853, as added by Section 21 of the act that added this
3 subdivision, have been met, this section shall become inoperative
4 on January 1, 2026, or the date certified by the department
5 pursuant to paragraph (2) of subdivision (k) of Section 15853, as
6 added by Section 21 of the act that added this subdivision,
7 whichever is later, and shall be repealed on January 1 directly
8 following that date.

9 SEC. 80. Section 15853 of the Welfare and Institutions Code,
10 as added by Section 21 of Chapter 738 of the Statutes of 2022, is
11 amended to read:

12 15853. (a) (1) An applicant that will provide an
13 intergovernmental transfer may submit a proposal to the department
14 for funding for the purpose of providing comprehensive health
15 insurance coverage to any child who meets citizenship and
16 immigration status requirements that are applicable to persons
17 participating in the program established by Title XXI of the Social
18 Security Act, and whose family income is at or below 317 percent
19 of the federal poverty level or, at the option of the applicant, at or
20 below 411 percent of the federal poverty level, in specific
21 geographic areas, as published quarterly in the Federal Register
22 by the United States Department of Health and Human Services,
23 as determined, counted, and valued in accordance with the
24 requirements of Section 1396a(e)(14) of Title 42 of the United
25 States Code, as added by the federal Patient Protection and
26 Affordable Care Act (Public Law 111-148) and as amended by
27 the federal Health Care and Education Reconciliation Act of 2010
28 (Public Law 111-152) and any subsequent amendments, and which
29 child meets both of the following requirements:

30 (A) Does not qualify for the optional targeted low-income
31 children group or the Access program.

32 (B) Does not qualify for Medi-Cal with no share of cost pursuant
33 to Chapter 7 (commencing with Section 14000) of Part 3.

34 (2) In its application, the applicant shall specify the income
35 level at or below 411 percent of the federal poverty level for which
36 it will provide coverage.

37 (3) The intergovernmental transfer amount is limited to the
38 expenditures which would be eligible for federal financial
39 participation.

1 (b) The proposal shall guarantee at least one year of
2 intergovernmental transfer funding by the applicant at a level that
3 ensures compliance with the requirements of any applicable
4 approved federal waiver or state plan amendment as well as the
5 department's requirements for the sound operation of the proposed
6 project, and shall, on an annual basis, either commit to fully
7 funding the necessary intergovernmental amount or withdraw from
8 the program. The department may identify specific geographical
9 areas that, compared to the national level, have a higher cost of
10 living or housing or a greater need for additional health services,
11 using data obtained from the most recent federal census, the federal
12 Consumer Expenditure Survey, or from other sources. The proposal
13 may include an administrative mechanism for outreach and
14 eligibility.

15 (c) The applicant may include in its proposal reimbursement of
16 medical, dental, vision, or mental health services delivered to
17 children who are eligible under the Access program or under the
18 Medi-Cal program as an optional targeted low-income children
19 group beneficiary, if these services are part of an overall program
20 with the measurable goal of enrolling served children in the Access
21 program or the optional targeted low-income children group.

22 (d) If a child is determined to be eligible for benefits for the
23 treatment of an eligible medical condition under the California
24 Children's Services Program pursuant to Article 5 (commencing
25 with Section 123800) of Chapter 3 of Part 2 of Division 106 of
26 the Health and Safety Code, the health, dental, or vision plan
27 providing services to the child pursuant to this chapter shall not
28 be responsible for the provision of, or payment for, those authorized
29 services for that child. The proposal from an applicant shall contain
30 provisions to ensure that a child whom the health, dental, or vision
31 plan reasonably believes would be eligible for services under the
32 California Children's Services Program is referred to that program.
33 The California Children's Services Program shall provide case
34 management and authorization of services if the child is found to
35 be eligible for the California Children's Services Program.
36 Diagnosis and treatment services that are authorized by the
37 California Children's Services Program shall be performed by
38 paneled providers for that program and approved special care
39 centers of that program and approved by the California Children's
40 Services Program. All other services provided under the proposal

1 from the applicant shall be made available pursuant to this chapter
2 to a child who is eligible for services under the California
3 Children’s Services Program.

4 (e) Notwithstanding any other provision of this section, an
5 applicant may submit a proposal to the department for the purposes
6 of providing comprehensive health insurance coverage to children
7 whose coverage is not eligible for funding under Title XXI of the
8 Social Security Act (42 U.S.C. Sec. 1397aa, et seq.), or to a
9 combination of children whose coverage is eligible for funding
10 under Title XXI of the Social Security Act and children whose
11 coverage is not eligible for that funding. To be approved by the
12 department, these proposals shall comply with both of the following
13 requirements:

14 (1) Meet all applicable requirements for funding under this
15 chapter, except for availability of funding through Title XXI of
16 the Social Security Act.

17 (2) Provide for the administration of children’s coverage by the
18 department through the administrative infrastructure serving the
19 Medi-Cal program, and through health care service plans serving
20 the Medi-Cal program.

21 (f) This section shall be implemented only to the extent any
22 necessary federal approvals are obtained, and federal financial
23 participation is available and not otherwise jeopardized.

24 (g) Notwithstanding any other provision of this part, the status
25 of any application previously submitted to, and approved by, the
26 Managed Risk Medical Insurance Board pursuant to former Part
27 6.4 (commencing with Section 12699.50) of Division 2 of the
28 Insurance Code shall not be altered as a result of the assumption
29 by the department, pursuant to this chapter, of the responsibilities
30 previously exercised by the Managed Risk Medical Insurance
31 Board.

32 (h) If at any time the director determines that the eligibility
33 criteria established for the program described in this section may
34 jeopardize the state’s ability to receive federal financial
35 participation under the federal Patient Protection and Affordable
36 Care Act (Public Law 111-148), any amendment or extension of
37 that act, or any similar federal legislation affecting federal financial
38 participation, the director may alter the eligibility criteria to the
39 extent necessary for the state to receive that federal financial
40 participation.

1 (i) Notwithstanding Chapter 3.5 (commencing with Section
2 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
3 and Chapter 4 (commencing with Section 12693.25) and Chapter
4 9 (commencing with 12693.70) of Part 6.2 of Division 2 of the
5 Insurance Code, the department may implement, interpret, or make
6 specific this section, in whole or in part, through all-county letters
7 or similar instructions, without taking any further regulatory action.

8 (j) For any child found eligible under this section, they shall
9 remain continuously eligible until they are five years of age. A
10 redetermination of eligibility shall not be conducted before the
11 child reaches five years of age unless the department or county
12 possesses facts indicating that the family has requested the child's
13 voluntary disenrollment, the child is deceased, the child is no longer
14 a state resident, or the child's original enrollment was based on a
15 state or county error or on fraud, abuse, or perjury attributed to the
16 child or the child's representative.

17 (k) (1) Implementation of this section is contingent on all of
18 the following conditions:

19 (A) All necessary federal approvals have been obtained by the
20 department pursuant to subdivision (f).

21 (B) The Legislature has appropriated funding to implement this
22 section after a determination that ongoing General Fund resources
23 are available to support the ongoing implementation of this section
24 in the 2024–25 fiscal year and subsequent fiscal years.

25 (C) The department has determined that systems have been
26 programmed to implement this section.

27 (2) The department shall issue a declaration certifying the date
28 that all conditions in paragraph (1) have been met. The department
29 shall post the declaration on its internet website and provide a copy
30 of the declaration to the Secretary of State, the Secretary of the
31 Senate, the Chief Clerk of the Assembly, and the Legislative
32 Counsel.

33 (l) ~~This~~ (1) *If the voters approve the addition of Chapter 7.5*
34 *(commencing with Section 14199.100) to Part 3 of this division at*
35 *the November 5, 2024, statewide general election, this section*
36 *shall become operative on January 1, 2025, or the date certified*
37 *by the department pursuant to paragraph (2) of subdivision (k),*
38 *whichever is later.*

39 (2) *If the voters do not approve the addition of Chapter 7.5*
40 *(commencing with Section 14199.100) to Part 3 of this division at*

1 *the November 5, 2024, statewide general election, this section*
2 *shall become operative on January 1, 2026, or the date certified*
3 *by the department pursuant to paragraph (2) of subdivision (b) of*
4 *Section 15832, as added by Section 137 of the act that added this*
5 *subdivision, whichever is later, and shall be repealed on January*
6 *1 directly following that date.*

7 *SEC. 81. Section 15877 is added to the Welfare and Institutions*
8 *Code, to read:*

9 *15877. (a) The department shall direct the participating health*
10 *plans to inform all program subscribers of the December 31, 2024,*
11 *transition of coverage as follows:*

12 *(1) (A) On August 1, 2024, the participating health plans shall*
13 *send an initial notification to all program subscribers. The initial*
14 *notice will inform subscribers of all of the following:*

15 *(i) That a plan-based enroller shall assist the subscriber in*
16 *applying to Medi-Cal or through the California Health Benefit*
17 *Exchange for other health care coverage.*

18 *(ii) That assistance may be available through the California*
19 *Health Benefit Exchange or clinic navigators and how to obtain*
20 *that assistance.*

21 *(iii) Information regarding where and how subscribers can*
22 *apply to the California Health Benefit Exchange for alternate*
23 *health care coverage.*

24 *(B) If a participating health plan has plan-based enrollers*
25 *through the California Health Benefit Exchange, the plan shall*
26 *direct the plan-based enrollers to assist the subscribers in*
27 *understanding their coverage options.*

28 *(C) Assistance to subscribers by plans shall provide information*
29 *on continuity with an existing provider to the extent possible.*

30 *(2) On October 1, 2024, the participating health plans shall*
31 *send a second notification informing all program subscribers that*
32 *coverage shall transition on December 31, 2024, for those who*
33 *are eligible for other coverage, and the notice shall include all of*
34 *the information that was included in the initial notification sent*
35 *on August 1, 2024.*

36 *(3) On December 1, 2024, the participating health plans shall*
37 *send a third notification informing all program subscribers that*
38 *coverage shall transition on December 31, 2024, for those who*
39 *are eligible for other coverage, and the notice shall include all of*

1 *the information that was included in the initial notification sent*
2 *on August 1, 2024.*

3 *(b) (1) Upon request from the California Health Benefit*
4 *Exchange, the department may disclose information to the*
5 *Exchange to assist program subscribers to transition into new*
6 *coverage pursuant to this section.*

7 *(2) The Exchange may disclose information obtained from the*
8 *department to outreach and marketing vendors under contract to*
9 *the Exchange.*

10 *(3) The Exchange shall not disclose information obtained from*
11 *the department to a certified insurance agent, a certified enrollment*
12 *counselor, or any other entity without the consent of the applicant,*
13 *except as provided in paragraph (2).*

14 *(4) Any outreach and marketing conducted pursuant to this*
15 *section shall include, in a conspicuous and easy-to-access manner,*
16 *the ability for individuals to decline all future outreach and*
17 *marketing.*

18 *(5) The Exchange shall take all necessary measures to safeguard*
19 *the confidentiality of any information obtained from the department*
20 *and shall at no time use or disclose that information for any*
21 *purpose other than to market and publicize the availability of*
22 *health care coverage through the Exchange to individuals whose*
23 *information the Exchange receives pursuant to subdivision (c).*
24 *The Exchange shall at all times only request, use, or disclose the*
25 *minimum amount of information necessary to accomplish the*
26 *purposes for which it was obtained.*

27 *(6) A person or entity that receives information from the*
28 *Exchange pursuant to this section shall take all necessary measures*
29 *to safeguard the confidentiality of any information obtained from*
30 *the Exchange and shall at no time use or disclose that information*
31 *for any purpose other than to market and publicize the availability*
32 *of health care coverage through the Exchange to individuals, as*
33 *directed by the Exchange. A person or entity shall at all times only*
34 *request from the Exchange, use, or disclose the minimum amount*
35 *of information necessary to accomplish the purposes for which it*
36 *was received.*

37 *(7) Information received by the Exchange from the department*
38 *shall both:*

1 (A) At all times be subject to applicable privacy and information
2 security-related requirements arising under both federal and state
3 law.

4 (B) Be destroyed in a manner that maintains confidentiality.

5 (8) The Exchange shall ensure that information disclosed to
6 outreach and marketing vendors or any other entity pursuant to
7 this section complies with paragraph (7).

8 (c) Sections 1373.65, 1373.95, and 1373.96 of the Health Safety
9 Code shall apply, whether or not the plan is licensed under Chapter
10 2.2 (commencing with Section 1340) of Division 2 of the Health
11 and Safety Code.

12 (d) The department shall cease to provide coverage through the
13 program on December 31, 2024, and on that date shall cease to
14 operate the program except as necessary to comply with
15 subdivision (e).

16 (e) The department shall complete payments to, or payment
17 reconciliations with, participating health plans or other
18 contractors, process appeals, and conduct other necessary
19 termination activities.

20 (f) Commencing November 1, 2024, and ending when the
21 transition of coverage is complete, the department shall provide
22 monthly updates to the Assembly Committees on Health and Budget
23 and the Senate Committees on Health and Budget and Fiscal
24 Review on the status of the transition of subscribers to other
25 coverage. These updates shall include the number of subscribers
26 who have transitioned and, to the extent available, to where, the
27 number remaining in the program, and any available demographic
28 information of each subscriber.

29 SEC. 82. Section 15893 of the Welfare and Institutions Code
30 is amended to read:

31 15893. (a) There is hereby continued in existence in the State
32 Treasury a special fund known as the Major Risk Medical
33 Insurance Fund that is, notwithstanding Section 13340 of the
34 Government Code, continuously appropriated to the department
35 for the purposes specified in Section 15894, Section 10127.16 of
36 the Insurance Code, and Section 1373.622 of the Health and Safety
37 Code.

38 (b) Funds may be deposited in the Major Risk Medical Insurance
39 Fund from one or more of the following accounts in the Cigarette
40 and Tobacco Products Surtax Fund:

- 1 (1) The Hospital Services Account.
- 2 (2) The Physician Services Account.
- 3 (3) The Unallocated Account.

4 (c) Effective July 1, 2017, the Major Risk Medical Insurance
5 Fund in the State Treasury is abolished and all moneys in the fund
6 shall be transferred to the Health Care Services Plan Fines and
7 Penalties Fund created pursuant to subdivision (d). Any remaining
8 balance, assets, liabilities, and encumbrances of the Major Risk
9 Medical Insurance Fund as of July 1, 2017, shall be transferred to,
10 and become part of, the Health Care Services Plan Fines and
11 Penalties Fund.

12 (d) There is hereby created in the State Treasury a special fund
13 known as the Health Care Services Plan Fines and Penalties Fund
14 that is, notwithstanding Section 13340 of the Government Code,
15 continuously appropriated to the department for the ~~purposes~~
16 ~~specified in Section 15894, Section 10127.16 of the Insurance~~
17 ~~Code, and Section 1373.622 of the Health and Safety Code.~~
18 *purpose of funding the nonfederal share of health care services*
19 *for children, adults, seniors, persons with disabilities, and*
20 *dual-eligible beneficiaries in the Medi-Cal program.*

21 (e) Any law that refers to the Major Risk Medical Insurance
22 Fund, including, but not limited to, a reference in this chapter to
23 the Major Risk Medical Insurance Fund or the “fund,” shall be
24 construed to refer to the Health Care Services Plan Fines and
25 Penalties Fund, effective July 1, 2017.

26 (f) Notwithstanding any other law, the Controller may use the
27 funds in the Health Care Services Plan Fines and Penalties Fund
28 for ~~cash flow~~ *cashflow* loans to the General Fund as provided in
29 Sections 16310 and 16381 of the Government Code.

30 *SEC. 83. (a) To the extent that these activities are an allowable*
31 *use of the AIDS Drug Assistance Program Rebate Fund, this*
32 *section authorizes the State Department of Public Health to spend*
33 *up to twenty-three million dollars (\$23,000,000) from the AIDS*
34 *Drug Assistance Program Rebate Fund to implement the following*
35 *programs, consistent with Sections 120955, 120956, 120960,*
36 *120972, 120972.1, and 120972.2 of the Health and Safety Code:*

37 (1) *Beginning January 1, 2025, or as soon as technically feasible*
38 *thereafter, increase AIDS Drug Assistance Program (ADAP) and*
39 *PrEP-Assistance Program financial eligibility standards from a*
40 *modified adjusted gross income that does not exceed 500 percent*

1 of the federal poverty level per year based on family size and
2 household income to 600 percent of the federal poverty level per
3 year based on family size and household income.

4 (2) Beginning January 1, 2025, or as soon as technically feasible
5 thereafter, increase the cap on premium payments from one
6 thousand nine hundred thirty-eight dollars (\$1,938) per month to
7 two thousand nine hundred ninety-six dollars (\$2,996) per month
8 for the Office of AIDS Health Insurance Premium Payment
9 program, the Employer-Based HIPP program, and the Medicare
10 Premium Payment Program.

11 (3) Beginning January 1, 2025, or as soon as is technically
12 feasible thereafter, modify the ADAP formulary to an open
13 formulary.

14 (4) Allocate five million dollars (\$5,000,000) annually for three
15 years, beginning July 1, 2024, to the Transgender, Gender
16 Nonconforming, and Intersex Wellness and Equity Fund to fund
17 services related to care and treatment for eligible individuals living
18 with HIV and AIDS.

19 (5) Allocate ten million dollars (\$10,000,000) annually for three
20 years, beginning July 1, 2024, to fund the Harm Reduction Supply
21 Clearinghouse to fund HIV prevention supplies to California
22 syringe access programs.

23 (6) Allocate two hundred thousand dollars (\$200,000) in the
24 2024–25 fiscal year, available until June 30, 2027, for the Office
25 of AIDS to create, develop, or contract out for a needs assessment
26 and analysis to identify needs for client navigation and retention
27 services for clients enrolled in a Ryan White HIV/AIDS Program
28 through the Office of AIDS.

29 (7) Allocate two hundred thousand dollars (\$200,000) in the
30 2024–25 fiscal year, available until June 30, 2027, for the Office
31 of AIDS to create, develop, or contract out for a needs assessment
32 and analysis aimed at understanding the potential needs for the
33 Pre-Exposure Prophylaxis (PrEP) Navigation Services Program.

34 (8) Allocate five million dollars (\$5,000,000) in the 2024–25
35 fiscal year, available until June 30, 2027, to distribute funding to
36 a community-based organization to make internal and external
37 condoms available pursuant to Section 35292.7 of the Education
38 Code, if Senate Bill 954 of the 2023–24 Regular Session becomes
39 effective, aimed at preventing the transmission of HIV and sexually
40 transmitted infections.

1 ***(b) The State Department of Public Health shall submit to the***
2 ***Legislature, as part of the 2025–26 Governor’s Budget, a plan for***
3 ***modernization and expansion of ADAP and related programs with***
4 ***a focus on addressing the epidemic of HIV/AIDS in California,***
5 ***including, but not limited to, the programs described in paragraphs***
6 ***(1), (2), and (3) of subdivision (a). The plan shall be developed in***
7 ***consultation with stakeholders and the Legislature and should***
8 ***consider whether the proposed activity is an eligible use of the***
9 ***AIDS Drug Assistance Program Rebate Fund, availability of***
10 ***funding, and whether it advances access to services.***

11 ***SEC. 84. The Legislature finds and declares that Section 22***
12 ***of this act, which adds Section 131380 to the Health and Safety***
13 ***Code, imposes a limitation on the public’s right of access to the***
14 ***meetings of public bodies or the writings of public officials and***
15 ***agencies within the meaning of Section 3 of Article I of the***
16 ***California Constitution. Pursuant to that constitutional provision,***
17 ***the Legislature makes the following findings to demonstrate the***
18 ***interest protected by this limitation and the need for protecting***
19 ***that interest:***

20 ***In order to protect personally identifying information of people***
21 ***presenting with reportable and nonreportable health conditions,***
22 ***it is necessary to limit access to this information if it is provided***
23 ***to other public entities pursuant to Section 131375 of the Health***
24 ***and Safety Code.***

25 ***SEC. 85. The amendments to Sections 7903, 16310, and***
26 ***30026.5 of the Government Code, Section 51312 of the Health and***
27 ***Safety Code, and Sections 5014, 5349, 5813.5, 5840.6, 5847,***
28 ***5849.35, 5890, 5891, 5893, 5895, 5899, and 14705 of the Welfare***
29 ***and Institutions Code, as amended by the act that added this***
30 ***section, shall become operative January 1, 2025.***

31 ***SEC. 86. No reimbursement is required by this act pursuant***
32 ***to Section 6 of Article XIII B of the California Constitution for***
33 ***certain costs that may be incurred by a local agency or school***
34 ***district because, in that regard, this act creates a new crime or***
35 ***infraction, eliminates a crime or infraction, or changes the penalty***
36 ***for a crime or infraction, within the meaning of Section 17556 of***
37 ***the Government Code, or changes the definition of a crime within***
38 ***the meaning of Section 6 of Article XIII B of the California***
39 ***Constitution.***

1 *However, if the Commission on State Mandates determines that*
2 *this act contains other costs mandated by the state, reimbursement*
3 *to local agencies and school districts for those costs shall be made*
4 *pursuant to Part 7 (commencing with Section 17500) of Division*
5 *4 of Title 2 of the Government Code.*

6 *SEC. 87. This act is a bill providing for appropriations related*
7 *to the Budget Bill within the meaning of subdivision (e) of Section*
8 *12 of Article IV of the California Constitution, has been identified*
9 *as related to the budget in the Budget Bill, and shall take effect*
10 *immediately.*

11 ~~SECTION 1. It is the intent of the Legislature to enact statutory~~
12 ~~changes relating to the Budget Act of 2023.~~